

Volunteer Application



Health Partners, Inc.
3070 Crain Hwy #101
P.O. Box 1865
Waldorf, MD 20601

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR APPLICATION

Thank you for considering a volunteer commitment to the uninsured of our community through Health Partners, Inc. It is important that you answer all items on this application. Please take time to list pertinent information carefully and completely. Our process is thorough because of the difficult, life preserving work we undertake. If additional space is needed, you may continue in the same format on a blank sheet of paper.

All information provided by the applicant on this form is subject to verification. All applications will be considered incomplete until two volunteer reference forms are submitted to Health Partners, Inc.

Personal Data: *(Please print clearly in ink)*

Name _____ Date of Birth: _____
Last First M. I.

Mailing Address: _____
Street City State Zip Code

Home Phone _____ Work Phone _____ Cell/Pager _____

E-Mail Address _____

Preferred Method of Contact: Home Phone Work Phone Cell Phone E-Mail Any/All

Are you Bi-lingual? Yes No If so, what language? _____

In case of emergency, whom shall we call?

Name _____ Phone _____ Relationship _____

Employment Information:

I am: Employed Full-Time Employed Part-Time Retired Unemployed Student

Current Employer _____ Title/Occupation: _____

Address _____
Street City State Zip Code

Education: *(Check all that apply and note degrees in progress)*

- H. S. Diploma Associate's Degree Bachelor's Degree Graduate Degree:
 Other Professional or Technical Qualifications or Certifications *(List all applicable degrees & credentials):*

(Please attach a photocopy of all current Professional Licenses)

Volunteer Information:

Previous Volunteer Experience, If Any:

Organization	Duties

Availability:

How often would you like to volunteer? One-time/Specific Project 1 per Month 1 per Week
 More than 1 per Week Evening /weekend outreach events Committee's (Event /Marketing)

Date you are available to start volunteering? _____

Please list the times you are available to volunteer

	Mon	Tues	Wed	Thurs	Fri	Sat
Mornings 9 -12						
Afternoon 12-1						
Evening 1 - 5:30						

Comments regarding your schedule or availability: _____

Service Opportunities/Interests: What do you want to do? Order your interest by number (First Choice = 1, Second Choice = 2, etc.) For specific details contact the Clinic.

<p align="center">MEDICAL CLINIC</p> <p>_____ Patient Screener (no medical background needed)</p> <p>_____ Patient Intake (CMA, CMT, LPN, RN) (patient history, medical records)</p> <p>_____ Patient Assessment (CMA, CMT, LPN, RN) (vital signs, c/c, triage)</p> <p>_____ Patient Discharge (LPN, RN) (assist provider, patient education, referrals)</p> <p>_____ Provider (Specialty) _____</p> <p>_____ Provider (MD, DO, CRNP) Primary Care</p> <p>_____ Patient Greeter (no medical background needed)</p>	<p align="center">DENTAL CLINIC</p> <p>_____ Provider (D.S.S.)</p> <p>_____ Hygienist (cleanings)</p> <p>_____ Dental Assistant (assist provider)</p> <hr/> <p align="center">DISPENSARY</p> <p>_____ Pharmacist (dispense meds, consult providers/patients)</p> <p>_____ Pharmacist Technician (assist pharmacist and provider)</p>
<p align="center">ADMINISTRATIVE</p> <p>_____ Receptionist (answer phones, file, schedule appts.)</p> <p>_____ Data Entry (computer skills necessary)</p> <p>_____ Translator</p> <p>_____ Newsletter (writer, editor, designer, etc.)</p> <p>_____ Community Outreach (public speaking)</p> <p>_____ Data Abstraction (statistics, MS Access)</p> <p>_____ Computer Administrator (manage networks, add users)</p> <p>_____ Web Designer</p> <p>_____ Special Events (fundraisers)</p> <p>_____ Committees (Q/A, Marketing, BOD, etc.)</p>	<p align="center">HEALTH EDUCATION</p> <p>_____ Diabetes Educator</p> <p>_____ Nutritionist</p> <p>_____ Dietician</p> <p>_____ Diet Technician</p> <p>_____ Counseling Services (LSW, MSW, Psychiatrists, Psychologist, LPC, CAC)</p> <p>_____ Case Manager (LSW, MSW) Contact by hone to support/encourage patient to follow up with referrals</p> <p>_____ Other</p>

For Statistical Purposes Only: (Please complete)

Gender: Female Male

Ethnicity: African American/Black Native American Asian/Pacific Islander Caucasian/White
 Hispanic/Latino Other

Name and Credentials as you would like them to appear on your Badge: _____

By signing below you certify that all of the above information is correct and true to the best of your knowledge.

Applicant Signature: _____

For Health Partners Staff Only:

Orientation Completed: _____

Application Received: _____

Start Date: _____



HEALTH PARTNERS, INCORPORATED

Primary Care for the Uninsured

P.O. Box 1865

Waldorf, MD, 20604

Office (301)645-3556 Fax (301)645-3932

Volunteer Professional Reference Check Form

Dear Sir or Madam:

Thank you for agreeing to be a reference for our potential volunteer. Please complete this entire form. Our volunteers must have at least two written references on file before they can provide services with our organization. You may return this reference form to the potential volunteer or directly to Health Partners in a sealed envelope with your signature written across the seal. Your cooperation and quick response is greatly appreciated.

Potential Volunteer's Name: _____

Reference Name: _____ Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip-Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Please check one column per question:

Questions	Unsatisfactory	Satisfactory	Excellent
How would you rank this individual's quality of work?			
How would you rank this individual's dependability?			
What is/was this individual like to interact with as a co-worker, employee, associate or student?			
How is/was this individual's involvement with clients/patients/customers/others?			
How would you rank this individual's leadership capabilities?			

How long have you known this individual? _____

What is your relationship to this individual? _____

In order to ensure the highest possible quality of care for our patients, please briefly describe any areas of concern that we should know about regarding this individual: _____.

Would you recommend this individual for a volunteer position with our organization? _____.

Additional comments can be written on the back of this form.

Reference's Signature: _____ Date: _____



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Potential Volunteer's Name: _____

Reference Name: _____ Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip-Code: _____

Phone: _____ Fax: _____ E-Mail: _____

Please check one column per question:

Questions	Unsatisfactory	Satisfactory	Excellent
How would you rank this individual's quality of work?			
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What is/was this individual like to interact with as a co-worker, employee, associate or student?			
How is/was this individual's involvement with clients/patients/customers/others?			
How would you rank this individual's leadership capabilities?			

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What is your relationship to this individual? _____

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HIPAA Acknowledgement for Volunteers

As a Health Partners Volunteer I understand that every Health Partners Client has the right to privacy under the Health Insurance Portability and Accountability Act. I understand and agree to make every reasonable effort to maintain and ensure client confidentiality.

I understand that I am responsible for reporting suspected privacy violations to Health Partners Privacy Officer (Executive Director).

By signing below I acknowledge that I understand the federal privacy practices and acknowledge that I can request clarification, training and assistance in regards to Health Partners, Inc. Privacy Practices at any time.

Printed Name: _____

Signature: _____

Date: _____



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Volunteer Fitness Statement

I am committed to protecting the health and welfare of the clients of Health Partners Inc., employees of Health Partners, Inc., and others, including the public, by providing a healthy and safe environment.

I am fully competent to perform and free from any physical or mental impairment that would prevent me from performing my assigned tasks. I hereby certify that I am of good health. If my health condition should change and impact my competency, I will notify Health Partners, Inc. immediately.

Print Name: _____

Signature: _____

Date: _____



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**Health Partners, Inc.
Hepatitis B and Influenza Vaccination Waiver Form
For Volunteers/Staff**

I hereby waive my right to a Hepatitis B and Influenza Vaccination. I voluntarily waive these vaccinations on my own accord. I understand that should I decide at a later date that I wish to be vaccinated I need to notify the Health Partners Executive Director immediately. I also understand and sign this statement that I am responsible for any adverse reactions that may result from waiving these vaccinations.

Printed Name: _____

Signature: _____

Date: _____



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**Health Partners, Inc.
Background Verification
Authorization for Release of Information**

In connection with my application for a volunteer or employment position, I authorize Health Partners, Inc. and their respective agents to solicit information about my criminal and driving background history; including, but not limited, to information as to my employment, education, military service, driving record, criminal record and general public records history.

I AUTHORIZE, WITHOUT RESERVATION, ANY GOVERNMENT AGENCY OR EDUCATIONAL INSTITUTION, CONTACTED BY HEALTH PARTNERS, INC. OR THEIR AGENTS, TO FURNISH THE ABOVE REFERENCED INFORMATION.

I release Health Partners, Inc. and their respective employees, agents and agencies providing information and reports about me from any and all liability arising out of the release of any such information or reports.

Health Partners, Inc. will retain all background reports as outlined in our Record Retention Policy and Procedure.

Name: _____

Signature: _____

Date: _____

SS#: _____



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SCOPE OF PRACTICE

In keeping with the Health Partners Mission, we provide free, quality health care to people who might not otherwise have access to such care. This care is provided on a non-judgmental basis with respect for the dignity of the individual patient. The clinic is structured around a volunteer provider base comprised of generalists and specialists, in addition to an on-staff Nurse Practitioner.

Health Partner's clinic is an ambulatory care facility providing services for commonly occurring acute illnesses, chronic conditions and preventative health/health maintenance needs of adults. Potentially severe or emergent care situations should be referred to appropriate health care settings with the requisite facilities and equipment. Chronic conditions with the likelihood of severe or emergent complications will be referred to Maryland's Medical Assistance or Primary Adult Care programs.

Definitions of services provided: (These definitions serve as examples and do not imply a complete listing.)

- **Self-limiting acute:** Upper respiratory infection, urinary tract infection, flu, sore throats, rashes, and/or pain.
- **Stable chronic conditions:** Type II diabetes, hypertension, hypothyroidism, asthma, seasonal allergies, arthritis, hyperlipidemia.
- **Prevention/health maintenance:** Education and cervical cancer screenings.
- **Procedures:** Minor incision and drainage without sutures and mobilization.

Services provided in clinic:

- Initial assessment of all presenting conditions.
- Dispensing of medications as ordered by licensed provider.
- Follow-up care after initial assessment **if** within Scope of Practice.
- Appropriate referrals to other health care facilities and/or providers. For example:
 - Any emergency care – **Call 911.**
 - Any unstable acute or chronic illness – refer to a hospital emergency room.
 - Any condition with the likelihood of severe or emergent complications – refer to Social Services for Medicaid or PAC application.
 - Community partner specialty providers.

I have reviewed and agree to work within the above Scope of Practice.

Signature: _____ Date: _____

Print Name: _____

VOLUNTEER PROVIDER SUPPLEMENTAL APPLICATION



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3070 Crain Hwy #101
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Waldorf, MD 20601

READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE FILLING OUT YOUR APPLICATION

Thank you for considering a volunteer commitment to the uninsured of our community through Health Partners, Inc. This form is to only be completed by medical providers (i.e. MD, DO, CRNP). It is important that you answer all items on this application. Please take time to list pertinent information carefully and completely. Our process is thorough because of the difficult, life preserving work we undertake. If additional space is needed, you may continue in the same format on a blank sheet of paper.

All information provided by the applicant on this form is subject to verification.

Name: _____

Please list the name, address and phone numbers for three physician references currently in practice in Maryland, preferably in Southern Maryland:

Physician's Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

CREDENTIALS

Please include copies of No. 1 – 3 credentials with your application.

1. Medical Licensure

State: _____ Number: _____ Expiration Date: _____

2. Proof of Malpractice Insurance

Company Name _____

Amount _____ Expiration Date: _____

Policy Number: _____

3. Name of an area hospital where you have active staff privileges.

Hospital: _____

4. UPIN # _____

5. DEA # _____

6. NPI # _____

7. Board Certifications, If Any: _____

For Staff Use Only: Confirmed Privileges Date: _____ Int. _____

ACCEPTANCE OF APPOINTMENT

I hereby accept appointment to the volunteer medical staff of Health Partners Free Clinic. I agree to abide by the rules and regulations of the Administration, Health Care Advisory Committee, medical staff, as well as any amendments added thereto.

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to the best of my knowledge and beliefs.

Signature of Applicant

Date

Please mail your completed application, together with signed Health Partners Scope of Practice to:

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