THE WAY CLINIC VOLUNTEER APPLICATION Date_____

Name (Last) (First) (Middle)

Mailing Address City State Zip

Work Telephone / Home Telephone / Cell Phone

Email: _____ _____
Emergency Contact Telephone Number

How did you hear about this volunteer opportunity? _____

Education _____ Birth Date _____

List any professional license, registration, or certificate you currently possess (include certificate/license number):

_____

List your most recent employment experience:

Employer Mailing Address Phone

Job Title Dates of Employment

Check the area(s) in which you would like to volunteer?

___Front Desk ___Translator ___Nurse ___Physician/ARNP ___Triage

___Other:

Do you speak Spanish? _____ Any other languages? _____

How often do you want to volunteer? _____

Which day(s) of the week would you prefer to volunteer? _____

Specify the days and time frames you are available to volunteer: _____

_____

Nurse/Triage ONLY Have you had a Hepatitis B vaccination? _____ Tetanus? _____

Have you ever been convicted of or plead nolo contendere to a driving or criminal offense?

Yes _____ No _____ If "yes", please explain, including types of offenses and dates:
[Please note that answering "yes" will not necessarily disqualify you from volunteering]

The Way El Camino FREE MEDICAL CLINIC

Release Form for Media Recording

I, the undersigned, do hereby consent and agree that The Way Free Medical Clinic, Inc., its employees, or agents have the right to take photographs, videotape, or digital recordings of me and to use these in any and all media, now or hereafter known, and exclusively for the purpose of The Way Free Medical Clinic, Inc.. I further consent that my name and identity may be revealed therein or by descriptive text or commentary.

I do hereby release to The Way Free Medical Clinic, Inc., its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that The Way Free Medical Clinic, Inc. is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____ Date: _____

Address: _____

Phone: _____

Signature: _____

Witness for the undersigned: _____

The Way Free Medical Clinic
Volunteer Confidentiality Policy

Given the nature of our work, it is imperative that we maintain the confidence of patient information that we handle in the course or our work. The Way Free Medical Clinic prohibits the release of any patient information to anyone outside The Way Free Medical Clinic except in limited circumstances. Discussions or disclosures of protected health information within the organization should be limited to the minimum necessary that is needed information to perform the work we do.

I understand the services provided to patients at The Way Free Medical Clinic are private and confidential and that I am bound to protect the privacy rights of The Way Free Medical Clinic patients. I understand that protected information exists in many forms, such as electronic, oral, written, or photographic, and that all such forms of information are strictly confidential and protected by federal and state laws that prohibit its unauthorized use or disclosure.

If, at any time, I knowingly or inadvertently breach patient confidentiality policy or procedures, I agree to notify a clinic staff member immediately. By signing below, I acknowledge that I have read and understand the above policy and I agree to observe it.

Signature: _____ Date: _____

Printed Name: _____