THE WAY CLINIC

INDEPENDENT STUDENT

Volunteer Application

Date: ______________

Name: ____

Home Address: ____

City: ______________________________ State: ______________

Personal Email: ____

Phone number: ______________________ Date of Birth: ______________

Emergency Contact: ____

What school do you currently attend? ______________________________

Your School Email: ____

Which Clinic staff member will you be primarily working with? (if known)

____

Do have any current medical professional license or certifications?

____

In what languages do you feel comfortable communicating with patients?

____

Do you agree to provide proof of the following vaccinations in a timely manner? Yes No

- MMR
- Hepatitis B
- Annual Flu
- Varicella (chicken pox)

The Way Free Medical Clinic requires all volunteers and staff to be background checked for safely measures. We may accept an existing background check within 5-years. If you do not have one, please use the provided link on our website. The cost of the check will be $19

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Initials

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: ____