



# Volunteer Care Clinic

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Dear Prospective Volunteer Health Care Professional:

Thank you for expressing an interest in volunteering at the Volunteer Care Clinic. We are excited you've chosen to invest in your community by helping us provide quality healthcare at no cost to uninsured individuals and families of Utah County. In this way we literally strengthen our community as we strengthen individuals. We take great pride in the services we offer, but we could not be as productive and effective as we are without the assistance from our amazing **VOLUNTEERS!**

Attached is our volunteer application. Your application will be complete when you have included the following items, to be submitted in one packet:

- \_\_\_\_\_ Completed application
- \_\_\_\_\_ Signed Forms
- \_\_\_\_\_ Copy of TB test results (must be within the year)\*
- \_\_\_\_\_ Copy of photo ID
- \_\_\_\_\_ Copy of any Licenses or Certificates to practice in your health care field

**PLEASE DO NOT SUBMIT YOUR APPLICATION UNTIL ALL COMPONENTS HAVE BEEN FULLY COMPLETED.** We cannot proceed with volunteer placement in our organization until all application materials have been received. Thanks for your cooperation!

Please direct completed applications to the **Volunteer Care Clinic Office, Attn: Volunteer Coordinator, 148 N 100 W Provo, UT 84603.** You may mail your application or drop it off at the office location in United Way of Utah County building.

We are glad that you are considering volunteering your time at the Volunteer Care Clinic – we assure you that your dedication is greatly appreciated by our staff and patients. You will surely gain an experience unparalleled while working alongside our remarkable staff and other volunteers. We appreciate your interest and look forward to welcoming you to the Volunteer Care Clinic team!

\* If you do not have current TB test results, then after the interview, the clinic can provide you with a voucher for a free TB test at the Health Department. However, you will be responsible for getting a chest X-ray if you test positive

*~ Please keep this front page for your reference. ~*



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## Licensed Volunteer Application

For Office Use Only- Initial when complete					
Interview:	Lisc/ID Check:	FTCA:	TB Test Date:	Volunteer Title:	Service (circle one): Tuesday or Thursday
Date:	Date:	Date:	Cleared to work:	Project Assigned:	Duration of service:

Personal Information				
First Name	M.I.	Last Name	Title	Date
Address		City	Zip Code	Phone
E-mail Address				Alternate Phone
Driver's license/ UT I.D. #	Date of Birth	Gender	Health Care Profession	
Emergency Contact Person		Relationship	Phone	
Employer			Phone	
Address		City	State	ZIP

Education		
College or University	Degree	Graduation Date
Address		City State Zip
Medical College or University	Degree	Graduation Date
Address		City State Zip

### Most Recent Residency, Fellowship, Preceptorship or Teaching Appointment

Facility (Full name)		Dates	
Address		City	State Zip
Type	Practitioner(s) Responsible for Performance (Chief of Staff, Chairperson of Departments, Other)		

### Certification

Certified by American Board of (Name of Board)		Date
Board Qualified (Name of Board)		Date
Specialty Board Status (Name of Board)	Are You Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date
If Not Certified, Give Present Status		

### Licensing

Medical License (Name of State)		Date Issued	Date Expired	License No.
Drug Enforcement Administration Number:	Date Issued	DEA Renewal Date:	Controlled Substance Administration (State Specific) License No.	Renewal Date:
Other (Name of License, County and State)		Date Issued	Date Expired	License No.

### Description of Practice

Please Briefly Describe All Past And Present Medical Practice, Including Office, Clinic, Hospital and Military

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## Please Answer The Following

1. Have your privileges at any hospital been denied, suspended, revoked or not renewed, or is there any action pending in that case?  
 Yes  No
2. Have you been involved in any liability action, or is there any such pending case?  
 Yes  No
3. Have you been charged or convicted of a drug related misdemeanor or felony, or is there action pending in such case?  
 Yes  No
4. Have you been asked to make any reform or compromise in connection with the Drug Enforcement Administration, or is there action pending in such case?  
 Yes  No
5. Have you been censored by any hospital, county/state, medical society, or is there action pending in such case?  
 Yes  No
6. Has there been any restriction in your state licensure, or is there action pending in such case?  
 Yes  No
7. Do you have any physical or emotional condition, including alcohol or drug dependence, which may affect or is likely to affect your ability to perform your professional duties?  
 Yes  No

\*\* If any of the above questions is answered YES, please provide additional information on another sheet of paper.

## Medical References

Please name two individuals who have personal knowledge of your current ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from clinic authorities. None of the individuals should be related to you by family or professional partnership or financial association. (Requested Source: Chief of Residency training program, department/service chief, practitioner in same specialty, administrator of hospital, etc.)

Name	Address	Phone
1. _____	_____	_____
2. _____	_____	_____

## Statement of Health Fitness

Do you have any physical or mental health condition(s) that would or may affect you ability to fulfill all the functions and obligations of serving as a volunteer health care provider at the Volunteer Health Clinic of Utah County with or without an accommodation?  No  Yes

If so, please explain:

If you would require an accommodation to fulfill such functions and obligations, please explain what accommodations you would require.

Are you dependent on Drugs or Alcohol?  No  Yes

If so, please explain:

Are you taking any medication that may affect either your clinical judgment or motor skills?

Are you under any limitations, in term of activity or work load?

I certify that the above information is true and correct to the best of my knowledge and I have not made any willful misrepresentations. I understand that verification of the above information may be required at any time for any reason. I grant permission to the Volunteer Care Clinic to conduct any background checks as may be necessary using the above provided information to verify any information herein. I understand that any willful falsification of information may result in the termination of my volunteer assignment.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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To help us better accommodate you and your scheduling preferences please complete the following:

I would like to volunteer

2 shifts a week       1 shift a week       other: \_\_\_\_\_

2 shifts a month       1 shift a month

I would prefer to volunteer on:

Tuesday       Thursday       on call

I am available to start:

\_\_\_\_\_

Duration of service (circle one):

at least 4 months       4-8 months       8-12months       12months+

Any comments regarding your schedule or availability: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Scope of Medical Services

Through the establishment of the Volunteer Care Clinic, we seek to provide free, quality health care for limited conditions to low income, uninsured members of our community. This care is provided with respect for the dignity of the individual patient. The clinic is structured around volunteers; including nurses and physicians.

The Volunteer Care Clinic is an ambulatory care facility providing services for commonly occurring self-limiting acute illnesses, stable chronic conditions and preventative health/health maintenance needs of children and adults. Potentially severe or emergent care situations will 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 the appropriate specialist for long term follow up.

To help you better understand the extent of care our clinic offers, we have listed the definition of services provided: (These definitions are to serve as an example and by no means implies a complete listing.)

- **Self-limiting acute:** Upper respiratory infection, urinary tract infection, flu, transmitted disease, sore throats, rashes, etc.
- **Limited chronic conditions:** (limited to diagnosis) Diabetes with oral hypoglycemic control, stable hypertension, hypothyroidism, asthma, seasonal allergies, osteoarthritis, etc.
- **Procedures:** Venipuncture, minor incision and drainage with sutures, sutures for minor lacerations.

Services provided in clinic:

Initial assessment of all presenting conditions.

If within Scope of Medical Services, follow-up care after initial assessment.

If not within Scope of Medical Services, appropriate referrals to other health care providers. For example:

- Any emergency care - Call 911.
- Any unstable acute illness - refer to a hospital emergency room.
- Any chronic condition – refer to Education Coordinator.

I have reviewed and agree to work within the above scope of practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



# Volunteer Care Clinic

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## Volunteer Confidentiality Agreement

I understand that it is the responsibility of all Volunteer Care Clinic volunteers to preserve and protect confidential patient, volunteer and business information. I understand confidential patient care information includes any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment as well as the patients and/or their family members records, test results, conversations, research records and financial information. I will not disclose medical information except as authorized by law or the patient or individual. I also understand that any information regarding fellow volunteers, such as addresses, telephone numbers, etc. is confidential and is not to be disclosed.

I agree that I will not breach confidentiality by releasing personal or confidential information which I have observe, hear or read during my time as a volunteer at the Volunteer Care Clinic.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



## Volunteer Care Clinic Temporary Privileges for Licensed Medical Professionals\*

The Volunteer Care Clinic strives to complete the privileging process for each medical professional who desires to serve at the clinic in a timely manner. However, the following temporary privileging policies have been established to allow medical professionals to begin serving before all privileging and credentialing requirements have been completed.

The Volunteer Care Clinic may grant temporary privileges to a LIP:

1. To meet important patient care needs for a limited period of time<sup>†</sup> (requires verification, which can be done by phone, of the provider's current licensure and current competence in the specific scope or content of patient care services he/she is to provide at the free clinic); or
2. To issue privileges for new volunteer free clinic health care professionals for a period not to exceed 120 days, requiring verification of:
  - a. Current licensure and that there is no history of current or previously successful challenges to licensure (can be done by phone);
  - b. Relevant training and experience (can be done by phone);
  - c. Current competence in the specific scope or content of patient care services he/she is to provide at the free clinic and ability to perform the privileges requested (can be done by phone);
  - d. NPDB history;
  - e. History of involuntary termination of medical staff membership at another organization (i.e., confirming that there is no history of this); or
  - f. History of involuntary limitations, reduction, denial, or loss of clinical privileges (i.e., confirming that there is no history of this)
  - g. Other criteria required by the policies and procedures of the free clinic (can be done by phone).

The Volunteer Care clinic does **NOT** provide temporary privileges for situations in which:

1. The LIP fails to provide all information necessary for the privileging process; or
2. Free clinic staff fails to verify performance data and other information in a timely manner.

In these situations, the free clinic must require that the LIP cease providing patient care in the free clinic until the privileging process is completed.

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\**Licensed Medical Professionals* include the following positions: physicians, registered nurses, nurse practitioners, phlebotomists, pharmacists and techs, and physicians assistants

<sup>†</sup>Examples of cases in which a free clinic could grant temporary privileges to a LIP in order to meet important patient care needs for a limited period of time include:

1. A current LIP becomes ill or takes a leave of absence, and another LIP is needed to cover patient care until the current LIP returns; or
2. A current LIP does not have the necessary skills to provide needed patient care.

## **Specific Consent to Information Exchange & Conditions of Consideration in Connection with Volunteer Care Clinic Appointment/Reappointment and/or Board Participation**

I am applying or reapplying for medical staff membership, clinical privileges, and/or panel participation with the Volunteer Care Clinic (VCC) entity, operations, and/or services. The scope of such application or reapplication is determined by other documents.

I understand that the VCC, as an entity is required to compile information so that they can make a fully informed decision about me and my relationship with them. This document is intended to facilitate that process. For convenience in this document, I refer to the processes of obtaining verification of my credentials, of checking my background, and of considering me for continued medical staff membership, clinical privileges, employment, or panel participation (as appropriate) as the "Process."

1. I have received or have had the opportunity to request, and I have had the opportunity to read employment or participation documents for the VCC to which I am re/applying. I acknowledge that such documents apply to me both in connection with the Process and in connection with my medical staff membership, clinical privileges, or panel participation, if granted, for the VCC.
2. On all application(s) and forms to the VCC, I have provided true, complete, and accurate information in connection with the Process. I represent to the VCC that such information provides an accurate, fair, and complete picture of my professional background, training, and experience for all the periods of time specified on the forms I have filled out. I acknowledge that any material omission or misstatement of information on such documents may be grounds for terminating my relationship with the VCC.
3. If extended medical staff membership, clinical privileges, and/or panel participation, I agree to abide by the bylaws, requirements, rule, and regulations of the VCC with which I am involved. I understand that my professional practice is subject to state and federal laws and regulations, and that persons, institutions, and entities involved in the Process may be protected by state and federal laws designed to encourage and protect good faith peer review and quality assurance activities.
4. I understand that it is necessary for the VCC to obtain detailed information about me in order to complete the Process. I understand that such information may be private, sensitive, privileged, and otherwise confidential. It is my request, and I hereby give my consent, that such information be disclosed to the VCC and received by them in the manner described in this document.

The information that may be disclosed shall include information about me that bears upon any of the following: my education, post-graduate specialty training, board certification, experience, competence, professional conduct, ethics, ability to work with others, quality assurance data and information, hospital and other affiliation(s) (such as other professional practice setting or participation with other health plans), utilization data, clinical privileges, disciplinary actions, malpractice coverage, claims history, judgments and settlements paid, litigation experience, state licensure, and controlled substance licensure, I intend that this consent include all information that reflects on my ability to safely, competently, and professionally perform the professional activities, and/or panel participation I have requested with the VCC.

I intend that this consent extends to all persons, institutions, and entities that have such information about me, including: colleges, universities, professional societies, hospitals, specialty boards, practice groups, clinics, insurance companies, partnerships, professional corporations, and employers, and to persons and committees associate with any of these. In connection with the Process, I also give my consent for all such persons, institutions, and entities to express their evaluation of me and to make recommendations about my professional skills, conduct, and ability to perform the clinical privileges, or the job for which I have applied. I also give my consent for the VCC and their medical staff, officers, agents,

committees and other volunteers involved in the Process to receive and act upon all such information, evaluations, and recommendations in connection with the Process.

5. I understand and agree that the information obtained about me by the VCC in the course of the Process may, upon request, be shared with other VCC personnel engaged in any similar Process involving me with the VCC in the future. However, I do not by this document consent to any release of information outside of the VCC. Beyond the consent described in this document, I do not consent to any general or public disclosure of any of the confidential, peer review information, evaluations or recommendations identified above. By signing this document, I do not give up any rights I have under the medical staff bylaws, fair hearing plans, or similar procedural documents of the VCC.
6. I recognize that the free exchange of information identified in this document is a necessary part of the credentialing, re-credentialing, privileging, peer review, contracting, affiliation, and employment process for the VCC. I also recognize that the possibility or threat of litigation and liability tends, as a practical matter, to discourage the exchange of these types of information. It is my intention to induce and encourage other persons, institutions, and entities to do the things identified in this document by removing the threat of litigation and liability as a result of their good faith actions to provide and receive information about me in the manner described in this document. To that end, I intend that the persons, institutions, and entities identified above, both within and outside of the VCC, will rely on this document as my consent to their action(s), as my release of them from liability in connection with the Process, and as my promise not to subject them to legal claims and lawsuits as a result of their good faith efforts to fairly and accurately provide the information that is request of them, which I acknowledge to be for my benefit to facilitate the Process. I intend that this paragraph will apply to persons, institutions, and entities supplying information, evaluations, and recommendations to the VCC, and also to all personas, committees, and entities involved in the Process for the VCC.
7. I understand that signing this document is an important part of the Process and that any change in this document as provided to me will cause my application or request to be incomplete and will delay the Process.
8. I intend that a copy of this document may be relied upon as if it were the original.
9. This document shall be effective for a period of two years following its execution.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
SSN