COMMUNITY MEDICAL CLINIC OF KERSHAW COUNTY
OUTREACH · ACCESS · MEDICAL HOME

Community Medical Clinic
Volunteer Application

Date__/___/_____

First Name _____Middle _____Last Name_____
Address_____
City_____ State_____ Zip Code_____
Home Phone_____
Cell Phone_____
Date of Birth____/___/____
Other (specify) _____
Email_____

Emergency Contact Information
Name_____
Telephone number_____

Heath issues CMC should be aware of_____

Hobbies_____
_____

How did you learn about the volunteer opportunity at CMC?
_____
_____

Professional licensure: Check all that apply
☐ CNA ☐ LPN ☐ PA ☐ RN ☐ RPH ☐ MA ☐ MD ☐ NP ☐ PHARM TECH
☐ Other_____

Please describe/ specify your skills and years of experience in each area listed below:
☐ Computer (programs Include):_____
_____
☐ Administrative/ clerical:_____
_____
☐ Medical office reception:_____
_____

☐ Medical office records:_____
_____
☐ Pharmacy:_____

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_____

Other:_____

_____

Positions Preferred: Circle all that apply

☐ Front Desk ☐ Patient Advocate ☐ Special Events ☐ Community Outreach
☐ Nurse ☐ Filing/Admin Helper ☐ Public Speaking

Date available to start ___/___/_____

General hours/ days available (hours are typically flexible, depending on position):

☐ Mornings 8am- 1PM Mon Tues Wed Thurs
☐ Mid-Afternoons 12pm- 3pm Mon Tues Wed Thurs
☐ Afternoons 2pm -6pm Mon Tues Wed Thurs

How often would you be willing to volunteer?

☐ Once a week
☐ Twice a week
☐ Once a month
☐ Other_____

Please indicate the times of year you are willing to commit to volunteer service with CMC (i.e. any time, summers only, school year, etc.)

Why do you want to volunteer with the Community Medical Clinic?

_____

_____

_____

Please read the following statement and sign below:
I will notify the Community Medical Clinic if I am unable to report for my volunteer duties on an assigned day.

Signed (your name) _____

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In order to be considered for volunteer positions, an individual may not be an active/recent patient at Community Medical Clinic or may not have family members who are active/ recent patients. Active/recent patient is defined as a patient who has received services at the Community Medical Clinic within the last 12 months.

I also agree to a background check by Goodhire.com on behalf of the clinic.

Are you or a family member an active/ recent patient at Community Medical Clinic? Yes☐ No☐

Volunteer Agreement To Maintain Confidentiality of Records and Information

I,_____, have been advised by the staff of the Community Medical Clinic, that all matters relating to the Community Medical Clinic and its patients are confidential. I will never discuss such matters outside the Community Medical Clinic or within hearing distance of any patient. Financial matters must never be disclosed. I understand that papers or other materials relating to patient care (for example, charts and schedules showing patients' names) should never be left in areas where other patients might see them.

I understand that the Community Medical Clinic restricts release of any information about its patients (including name, address, age, sex, nature of the medical problem, reason for a visit, medications, general condition, as well as all personal of identifying information) to anyone, including members of the public or press, other professionals, pharmacies, families, and friends without the patient's written authorization and release from the patient or the patient's guardian. I agree not to disclose any patient or chart information to third parties or persons outside this office, including my family and friends, unless I am specifically authorized to do so by the patient writing. I understand that this restriction applies to telephonic requests and requests sent by facsimile and that I am not to reveal or disclose any information in response to a request made by telephone or the facsimile.

I also understand that any subpoena which requires the photocopying of any portion of a patient's chart or charts must be reviewed by the Nurse Practitioner or Executive Director before chart is copied.

I will exercise discretion when using the telephone at the Community Medical Clinic. I realize it is important not to leave messages containing patient information on answering machines or with other parties. I will leave a message requesting that the patient call "the Community Medical Clinic "and a number to call.

I understand that breach of this confidentiality agreement may lead to disciplinary action, up to and including termination.

Date _____Volunteer Signature_____

Print name of Volunteer_____