

FRIENDSHIP CLINIC

YOUR BRIDGE TO HEALTH

Volunteer Application

Name (Last, First, MI) Please Print _____ Date: _____
Home Phone # _____

Street or Mailing Address _____ Work Phone # _____

City, State, Zip Code _____ Cell/Other Phone # _____

Email Address _____

Employer _____ Occupation _____

Previous Work Experience _____ Professional License (Please attach copy) _____

Volunteer Experience _____

Two References (Not Relatives)

Name _____ Address _____ Telephone # _____

Name _____ Address _____ Telephone # _____

Indicate the day(s) of the week you are available to volunteer:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Indicate the time of day you are available to volunteer:

Mornings Afternoons Evenings Any time

Indicate your areas of interest and/or expertise:

- | | | |
|--|--|--|
| <input type="checkbox"/> Physician/NP/PA | <input type="checkbox"/> RN | <input type="checkbox"/> Counselor |
| <input type="checkbox"/> Receptionist/Clerical | <input type="checkbox"/> Social Work | <input type="checkbox"/> Phlebotomy |
| <input type="checkbox"/> Interpreter | <input type="checkbox"/> Fundraising | <input type="checkbox"/> Janitorial |
| <input type="checkbox"/> Handyman/woman | <input type="checkbox"/> Computer Tech Support | <input type="checkbox"/> Other (specify) |

Volunteer Code of Conduct and Confidentiality Agreement

As a Volunteer of The Marie Blanchard Friendship Clinic, my signature signifies that I agree with the following statement and will conduct myself in accordance with the following standards.

Mission of the Marie Blanchard Friendship Clinic:

To provide free basic healthcare to low-income individuals and families who have no or inadequate insurance coverage with emphasis on health promotion and disease prevention.

I agree to serve as a volunteer and commit to the following:

- To perform my volunteer duties to the best of my ability.
- To adhere to the rules and procedures, including record keeping requirements and client confidentiality.
- To meet time and duty commitments, or to provide adequate notice so that alternate arrangements can be made.

I promise to treat each patient as the most important patient in my care, attending promptly to his or her needs and concerns, acting always in his or her best interest.

I recognize that as a volunteer I will come to know confidential information found in a hospital setting. I will not disclose or discuss such privileged information with anyone. I will not reveal names of patients, nor visit a patient I know unless that information has come to me outside of clinic records. Any specific patient and physician medical information will not be discussed in any public area of the clinic, or outside the clinic.

I understand that any breach of confidentiality will result in the termination of my volunteer position.

Signature

Date

(Code **WHITE** = Confidentiality – **W**hen **H**earing **I**ndiscreet **T**alk, **E**nd it.)