FRIENDSHIP CLINIC

*YOUR BRIDGE TO HEALTH*

THE MARIE BLANCHARD

RN Application

Date:

Name:

DOB:

Address:

Telephone:

**Two References** (Not Relatives)

Name:

Address:

Telephone:

Name:

Address:

Telephone:

Last 4 # S.S. \_\_\_\_\_\_\_\_\_\_

This is for FTCA malpractice insurance credentialing. [**https://bphc.hrsa.gov/ftca/freeclinics/policies.html**](https://bphc.hrsa.gov/ftca/freeclinics/policies.html) **Free Clinic Policy Guide**

Idaho Nursing License #

School of Nursing

Degree Received

Graduated Date

Copy of current CPR/AED Training

Copy of current TB or QuantiFERON Gold Results

Immunization Records

Photo I.D.

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In the **last year,** have you performed:

\_\_Yes \_\_No Vital Signs

\_\_Yes \_\_No Blood glucose w/ glucometer

\_\_Yes \_\_No Blood oxygen saturation

\_\_Yes \_\_ No Urine dip

\_\_Yes \_\_ No Quick Strep Test

\_\_Yes \_\_No EKG 12 Lead

\_\_Yes \_\_ No Staple removal

\_\_Yes \_\_ No Wound care

\_\_Yes \_\_No Nebulizer

**Volunteer Code of Conduct and Confidentiality Agreement**

As a Volunteer of The Marie Blanchard Friendship Clinic, my signature signifies that I am in agreement 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.)

5/2024