**OUR LADY OF GUADALUPE**

***Free Clinic***

P.O. Box # 731

Worthington, MN 56187

507-329-2123

***Volunteer Application Form (v3.0)***

*Thank you for expressing desire to serve as a volunteer at Our Lady of Guadalupe Free Clinic. The clinic was founded as a Catholic charitable work in 2011 by Father James Callahan and Dr. (Deacon) David Plevak. It is with great reverence, compassion and concern that, in full union with the Catholic Church, we provide free healthcare to uninsured people of all faiths, nationalities and creeds through the many volunteers and precious resources that God provides.  Our gaze recognizes each patient’s full and unique human dignity as together with the Creator we seek to heal and care for them from conception to natural death.*

*We greatly value your call to serve our patients. To prayerfully consider your offer of time and talent, we ask that you complete the forms below and follow the submission guidelines on page 3.*

*There are inherent risks associated with providing patient-care services. These risks include but are not limited to exposure to infectious agents and communicable disease conditions whether air-borne, through physical contact or via contamination by blood or body fluids. By submitting this application, you are acknowledging and accepting these risks and personal financial responsibility for your own preventive care and your treatment should an adverse event occur. Our Lady of Guadalupe Free Clinic strongly recommends all volunteers have a tuberculin skin test at least annually.*

*Volunteers who are applying for direct patient care activities will ideally be 21 years of age or older. People under age 21 are welcome and encouraged to volunteer for much needed non-patient care support roles associated with the medical clinic. If questions arise while completing the information below, please contact Our Lady of Guadelupe Free Clinic Office at 507 329 2123. Dios te bendiga!*

**Full Name:** Click here to enter text.

**Street Address:** Click here to enter text.

**City:** Click here to enter text.

**State:** Click here to enter text.

**Zip Code:** Click here to enter text.

**Home Phone:**      and/or **Cell Phone:**       **Work Phone (optional):**

**Emergency Contact Name and Phone:** Click here to enter text.

**E-mail:** Click here to enter text.

**Employer and Occupation (if currently employed):** Click here to enter text.

**Have you had previous volunteer experiences that you would like to share?** Click here to enter text.

***Personal Health History***

**Complete this section if volunteering for a direct patient care role**

**Indicate communicable diseases that you have had:**

 ☐Chicken Pox ☐Mumps ☐German measles

 ☐Red measles (7 Day) ☐Tuberculosis ☐other: Click here to enter text.

**Indicate the vaccinations that you have had. Include dates where indicated:**

 Oral Polio Series Completed: ☐ Yes ☐ No

 Diphtheria-Pertussis-Tetanus (DPT)

 Td Date: Click here to enter a date.

 Tdap Date: Click here to enter a date.

 Measles-Mumps-Rubella: Click here to enter a date.

 Influenza Vaccine: Click here to enter a date.

 Hepatitis B Vaccination Series (optional):

 Date: Click here to enter a date.

 Date: Click here to enter a date.

 Date: Click here to enter a date.

**Indicate the dates and results of the following required Health Screenings:**

|  |  |  |
| --- | --- | --- |
| *Test* | *Date* | *Result* |
| Tuberculin Skin Test | Click here to enter a date. | ☐Positive ☐Negative ☐Not Tested |
| Rubella Titer | Click here to enter a date. | ☐Positive ☐Negative ☐Not Tested |

**Do you have any limitations that may affect your ability to provide certain volunteer services?** ☐ Yes ☐ No

**If yes, please describe:** Click here to enter text.

**Please check all positions for which you wish to be considered. If you possess certification, credentialing, or license, please provide your registration information.**

***Skills/Certification/Credentials***

**☐** Certified Laboratory Technician: Lic/Reg #: Click here to enter text.

**☐** Certified Nurse Practitioner: Lic/Reg #: Click here to enter text.

**☐** Clerical/Receptionist/Medical Records

**☐** ECG Technologist: Lic/Reg #: Click here to enter text.

**☐** Dietitian: Lic/Reg #: Click here to enter text.

**☐** Interpreter: Spanish: ☐ Somalia: ☐ Arabic: ☐ Mam: ☐ Other ☐: Click here to enter text.

**☐** Laboratory Specialist: Lic/Reg # Click here to enter text.

**☐** Licensed Practical Nurse: Lic/Reg # Click here to enter text.

**☐** Occupational Therapist: Click here to enter text.

**☐** Other Professional: Click here to enter text.

**☐** Pharmacist: Lic/Reg # Click here to enter text.

**☐** Physician - Specialty/Subspecialty: Click here to enter text.

 Lic/Reg #: Click here to enter text. NPI #: Click here to enter text.

**☐** Physician Assistant: Lic/Reg #: Click here to enter text.

**☐** Physical Therapist: Click here to enter text.

**☐** Psychologist: Lic/Reg #: Click here to enter text.

**☐** Radiologic Technologist: Lic/Reg #: Click here to enter text.

**☐** Registered Nurse: Lic/Reg #: Click here to enter text.

**☐** Registered Sonographer: Lic/Reg #: Click here to enter text.

**☐** Respiratory Therapist: Lic/Reg #: Click here to enter text.

**☐** Social Worker: Lic/Reg # Click here to enter text.

**☐** Support Role (describe skill set/role desired): Click here to enter text.

**Preferred OLGFC Volunteer Location: ☐**Clinic **☐**Office **☐**Both **☐**Other: Click here to enter text.

*Clinics run 6 to 8 times per year – approximately every 6 to 10 weeks - on a Saturday from 8AM to 5PM)*

-------------------------------------------------------------------------------------------------------------------------------

**Submission**

* *Please print, sign and date each page of this application and mail it to the address above prior to the first clinic date that you wish to volunteer. By signing you attest that all information provided is true and correct, you are qualified to volunteer as indicated, you acknowledge the risk and personal financial responsibility associated with volunteering, and you agree to practice while serving with the clinic in full fidelity with the Ethical and Religious Directives for Catholic Health Care Service. The directives will be provided upon request or can be accessed at www.usccb.org*
* *If appropriate, include documentation of current state licensing and/or professional credentials.*
* *Include the confidentiality agreement (see below).*
* *Include, as professionally necessary, proof of professional liability/malpractice insurance coverage. if you are a current employee of Mayo Clinic, your malpractice coverage has been arranged.*
* *A background security check may be requested for volunteers in direct patient care activities if not currently employed in a medical field. Any associated fees will be covered by the clinic.*
* *Thank you again for considering Our Lady of Guadalupe Free Clinic. A member of the clinic staff or board of directors will be in contact with you regarding your application.*

***Motivation***

*Please share a brief note telling us about yourself and what motivates you to volunteer at Our Lady of Guadalupe Free Clinic. Tell us what you hope to gain from your experience. Please list any support roles that you might also be interested in serving in, such as fund-raising, prayer groups, set-up/tear-down, food, lodging, etc.*

Click here to enter text.

**Our Lady of Guadalupe Free Clinic**

***Confidentiality Policy Agreement***

The Board of Directors for Our Lady of Guadalupe Free Clinic calls your attention to our *Confidentiality* and *Protected Health Information* policies. All persons or entities who provide products or services to Our Lady of Guadalupe Free Clinic agree to conduct themselves in accordance with these policies and hold in confidence all information concerning patients, volunteers, employees and business operations.

Confidential information includes all information whether paper-based, electronic, auditory or visual, related to the operations of the clinic including, but not limited to:

* Patient personal and medical information designated or defined as protected health information (PHI) by all branches of the state or federal government
* Patient appointment or scheduling information
* Patient names, addresses, phone numbers and all other personal information
* Patient financial information
* Volunteer or employee personal or employment information
* Social security numbers and other personal identifiable information
* Electronic environment passwords and/or other data security measures
* Marketing and general business strategies
* Any information marked “confidential”
* Any patient, volunteer or employee personal information heard or seen while acting as a volunteer or employee

Only Our Lady of Guadalupe Free Clinic physicians, health-care practitioners, or other authorized individuals, may access, use or release patient personal and/or medical protected health information as allowed by law. Such matters are strictly confidential between the health care provider and the patient.

Authorized individuals must refrain from revealing any confidential information concerning patient, volunteer, employee or business operations information. Carelessness or thoughtlessness in this respect, leading to the release of such information, is not only wrong ethically but may involve the individual and the clinic legally. Photography or recording of patients by any means is strictly prohibited within the clinic.

------------------------------------------------------------------------------------------------------------------------------------------

I have heard or read the above policy statement and the *Confidentiality* and *Protected Health Information* Policies. I understand the contents and agree, unless legally authorized, not to ***access, use or release*** confidential information regarding patients, employees and/or business operations as described above and in the *Confidentiality* Policy. I also understand that unauthorized access, use or release of any and all confidential information at Our Lady of Guadalupe Free Clinic may be a violation of state and/or federal law and cause for immediate legal action by a patient or Our Lady of Guadalupe Free Clinic.

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JOB TITLE/ROLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rev 1.7 10-7-2019