WILLING HELPERS MEDICAL FREE CLINIC **VOLUNTEER APPLICATION**

NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET

_____
CITY STATE ZIP

PHONE: _____ EMAIL: _____

SSN: _____ DOB: _____

POSITION (Circle One):

NURSING MEDICAL ASSISTANT PHLEBOTOMIST CLERICAL OTHER: _____

STATE LICENSE (IF APPLICABLE): _____ ARE YOU A US CITIZEN (CIRCLE ONE): YES NO

HAVE YOU EVER BEEN CONVICTED OF A FELONY (CIRCLE ONE): YES NO

IF YES, EXPLAIN: _____

EDUCATION

HIGH SCHOOL: _____ COLLEGE: _____ DEGREE: _____

LIST PAST TWO PREVIOUS EMPLOYMENTS:

1. _____
2. _____

LIST TWO PERSONAL REFERENCES:

1. _____
2. _____

DATE: _____ SIGNATURE: _____

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

I acknowledge that in connection with my duties as a volunteer for WILLING HELPERS MEDICAL CLINIC, I may gain access to the demographic information and personal health information (as defined herein), of patients being serviced through the clinic, which is required by law to be kept confidential. For and in consideration of my participation in the clinic, I agree as follows:

1) **Demographic Information** refers to information that identifies an individual (name, address, telephone number, etc.)
2) **Personal Health Information** relates to past, present, or future physical and/or mental health conditions or any other information disclosed by a patient or discussed with a patient regarding the provision of clinical services provided through the clinic.

I understand that the clinic's leadership has the expectation that I will hold in confidence and will not disclose, directly or indirectly, the personal information or any portion therefore communicated, discussed, delivered or made available by any patient.

I acknowledge that my obligation under this agreement remains in effect indefinitely.

I will take reasonable precautions to ensure that the confidentiality of patients' personal information is maintained and will follow all clinic procedures in that regard.

The clinic's policy is to safeguard access to personal information by taking reasonable steps to keep the information secure. I will not discuss personal information in public places or outside the clinic.

As a representative of the clinic, I acknowledge that I may only disclose personal information to volunteers or authorized advisors and consultants of the clinic with a specific need to know such information in order to serve the patient.

I also understand that the Health Information Privacy and Portability Act (HIPPA) set forth by the Department of Health and Human Services requires that all clinic personal maintain the privacy of all patient health information obtained in complete confidence. The HIPPA law passed in 1996 allows every patient the protection of privacy with regard to their health information.

Printed Name: _____

Signature: _____ Date: _____