PALMETTO COMMUNITY HEALTH CARE

Compassionate Medical Care for Our Uninsured Neighbors

VOLUNTEER APPLICATION

All volunteers at Palmetto Community Health Care (PCHC) formerly known as York County Free Clinic play a vital role in providing quality care in a compassionate manner. We appreciate your interest in volunteering. To provide a safe, secure, and confidential environment, all volunteers must be at least 18 years od age, participate in training for HIPAA, OSHA, and cultural awareness through a Volunteer Orientation. Likewise clinical or licensed volunteers are required to maintain a current CPR-BLS certification, maintain current active license or certifications (MD, NP, RN, LPN, CMA, CNA etc..). A national criminal and background check will be conducted for a charge to the volunteer of $15.00. Please complete the following application and review all information in this packet. You will be contacted with in one – two weeks for a brief interview to discuss your partnership with PCHC.

Thanks for your willingness to serve

Did you include

- ☐ Completed Application
- ☐ 15.00 background fee (cash or money order)
- ☐ Resume (if available)
- ☐ Copy of Government issued ID
- ☐ Copy of Professional Licensure (medical)
- ☐ CPR-BLS Certification (medical)

I _____understand and agree that submitting this application form does not automatically register me as a Palmetto Community Health Care Volunteer, and that there may be certain qualifications I must meet, including the acceptance of established volunteer policies and procedures before I may begin volunteering.

Signature: _____ Date: _____

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VOLUNTEER STATEMENT OF ETHICS AND CONFIDENTIALITY OF PATIENT INFORMATION

I, _____, do pledge to provide patient care to the best of my ability as a volunteer with Palmetto Community Health Care. I will maintain strict confidentiality of all aspects of patient care. Confidential Information is defined as a privileged information found in patient's medical record. All information relating to a patient's care, treatment, condition, or in information contained in the patient's record constitutes confidential information. Employees or volunteers shall never discuss a patient's condition or financial circumstances with friends or family members, other PCHC volunteers or staff, and any other outside individuals. Disclosure that a patient is seen in our clinic could also indicate the nature of the patient's circumstances, and therefore, should not be release without proper authorization. Every effort should be made to protect patient confidentiality. Any discussion of patient information is subject to discharge from employment or volunteer services in the clinic. I will treat patients with care, compassion, and understanding. I agree to be courteous to patients, staff, and fellow volunteers.

I have read and agreed to the above policy relating to ethic and confidentially.

Signature: _____ Date: _____

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Name:_____
(First) (MI) (Last)
Address: _____

City/State/Zip: _____
Sex (circle one): Male Female Date of Birth: _____SS#_____

Contact Phone: _____E-Mail Address_____

Occupation: _____

Driver's License # _____

How did you learn about the volunteer opportunities at PCHC?

_____

Why would you like to volunteer at PHCH?

_____

_____

Explain the experience or skills that would be beneficial to your volunteer position?

_____

_____

Volunteer Interest (please check)

Clerical

- ☐ Clerical Front Office
- ☐ Event Planning
- ☐ Translator
- ☐ Recertification Specialist
- ☐ Fundraising
- ☐ Grant Writing
- ☐ IT Computer

Medical

- ☐ Medical Professional (RN,LPN,CMA)
- ☐ Counseling
- ☐ Nutrition/ Dietician
- ☐ CPR Instructor
- ☐ MLT or Phlebotomist

We prefer that all volunteers commit to helping weekly or, at a minimum, once a month for a period of at least 6 months. The volunteer time will be 4-hour increments from 8am-12pm or 1pm- 5pm. Thank you for your service. Please indicate the days and times you are usually available to volunteer. Please arrive at least 5-10 mins before the start time of your shift.

Morning 8am- 12pm: Mon Tue Wed Thu 1x per week 1x per month
Other time please specify: _____

1pm- 5pm: Mon Tue Wed Thu 1x per week 1x per month
Other time please specify: _____

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In order to be considered for volunteer positions, and individual may not be an active or recent patient at PCHC or may not have family members who are active/recent patients. Active/ Recent patient is defined as a patient who has received services at PCHC with in the last 12 month. Are you or a family member an active/recent patient at PCHC yes, or no? _____

Have you ever been charged with or alleged to have committed unprofessional conduct, professional incompetence, negligence, or malpractice in a criminal or civil proceeding Yes or No If you answer yes, please explain? _____

_____

Have there every been any charges, complaints, or grievance filed, formally, or informally with any licensing authority in any state, province, territory, or jurisdiction against you, regardless of the Yes or No If you answer yes, please explain? _____

_____

_____

Emergency Contact: _____

Relationship _____ Phone_____

Please provide the name and phone number of people we contact for personal and /or professional references:

Name _____Phone_____

Email_____

Name _____Phone_____

Email_____

A Background check will be conducted upon approval of your application Please return this application with $15.00 cash or money order to complete background check. Make money orders out to PCHC.

Signature: _____ Date: _____

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PALMETTO COMMUNITY HEALTH CARE

(NAME OF BUSINESS)

Personal Information Needed for Background Investigation

The following information will be used to conduct a background investigation. Please ensure the information below is accurate to the best of your knowledge. Please note that your personal information is confidential and will only be used for background investigation purposes.

Confidential Information Used for Background Checking Purposes Only

PRINT FIRST NAME	MIDDLE INITIAL	LAST	SOCIAL SECURITY NUMBER	DATE OF BIRTH

DRIVER'S LICENSE NUMBER	STATE OF ISSUANCE	PHONE	EMAIL

PRESENT ADDRESS	CITY, STATE, ZIP	COUNTY

Please list any previous addresses you have had in the past 7 years:

STREET ADDRESS, CITY, STATE, ZIP	COUNTY	DATES (FROM / TO)
STREET ADDRESS, CITY, STATE, ZIP	COUNTY	DATES (FROM / TO)
STREET ADDRESS, CITY, STATE, ZIP	COUNTY	DATES (FROM / TO)

Please list any former names (i.e. maiden or otherwise) you have used in the past 7 years (including years used):

[1] FORMER NAME	DATES (FROM / TO)
[2] FORMER NAME	DATES (FROM / TO)
[3] FORMER NAME	DATES (FROM / TO)
[4] FORMER NAME	DATES (FROM / TO)

Sign Here Signature: _____ Date: _____

Acknowledgement and Authorization Regarding Background Investigation

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I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION, A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT, AND RIGHT TO OBTAIN MORE INFORMATION REGARDING INVESTIGATIVE CONSUMER REPORTS. I certify that I have read and understand those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by PALMETTO COMMUNITY HEALTH CARE ("the Company")
(NAME OF BUSINESS)
at any time during the hiring process and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, insurance company or other party to furnish any and all background information requested by True Hire, LLC, 11730 Cleveland Ave., N.W., Uniontown, OH 44685, 800.262.7301, info@true-hire.com (the Agency") and/or the Company.

State of Washington applicants and employees only: If the Company requests an investigative consumer report from a consumer reporting agency, you have the right to receive a complete and accurate disclosure of the nature and scope of the investigation requested by Company. You also have the right to request from the Agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.
Massachusetts and New Jersey applicants and employees only: You have the right to inspect and promptly receive a copy of any investigative consumer report requested by the Company by contacting the Agency identified above directly.
New York applicants and employees only: You have the right, upon request, to be informed of whether or not a consumer report was requested from a consumer reporting agency by contacting the Agency. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You may also inspect and receive a copy of the report by contacting the Agency with the contact information above. By signing below, you also acknowledge receipt of Article 23-A of the NY Correction Law.
Minnesota applicants and employees only: You have the right, upon written request to the Agency, to receive a complete and accurate disclosure of the nature and scope of any consumer report. The Agency must make this disclosure within five days of receipt of your request or of Company's request for the report, whichever is later. Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ❑
Oklahoma applicants and employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ❑
California applicants and employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ❑

Sign Here Signature: _____ Date: _____

Print Name: _____