

Date \_\_\_\_\_

**WESTERN STARK FREE CLINIC**  
**820 Amherst Ave., N.E.**  
**Massillon, Ohio 44646**  
**330.834.1546**

**VOLUNTEER APPLICATION**

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Emergency Contact Name & Telephone \_\_\_\_\_

Please identify your profession, and if appropriate, indicate whether you would be providing services on-site or off-site:

<input type="checkbox"/> <b>Dentist</b> on-site or off-site	<input type="checkbox"/> <b>RN</b>	<input type="checkbox"/> <b>Pharmacy Support</b>
<input type="checkbox"/> <b>Physician</b> on-site or off-site	<input type="checkbox"/> <b>LPN</b>	<input type="checkbox"/> <b>Psychologist</b>
<input type="checkbox"/> <b>Medical Resident</b>	<input type="checkbox"/> <b>APN</b>	<input type="checkbox"/> <b>Social Work</b>
<input type="checkbox"/> <b>Medical Student</b>	<input type="checkbox"/> <b>Medical Assistant</b>	<input type="checkbox"/> <b>Lay Volunteer</b>
<input type="checkbox"/> <b>Other Healthcare Professional</b>	<input type="checkbox"/> <b>Pharmacist</b>	<input type="checkbox"/> <b>Other</b>

What is your specialty? \_\_\_\_\_

Please provide evidence or current copies of the following (if applicable):

Photo I.D.

Professional License # \_\_\_\_\_

Please circle preferred days you are available: **M T W TH F**

Please circle how often would you be able to volunteer:

**1 time per week 1 time per month 2 times per month other**

Date \_\_\_\_\_

Please circle times available to volunteer:       **Mornings**       **Afternoons**

How did you hear about the clinic? \_\_\_\_\_

Additional skills you would like to contribute \_\_\_\_\_

Are you bi-lingual? \_\_\_\_\_ Language \_\_\_\_\_

**PERSONAL OR PROFESSIONAL REFERENCE**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

**PLEDGE OF CONFIDENTIALITY**

I \_\_\_\_\_ fully understand that all medical records and Protected Health Information are confidential material to be protected for the sake of the patient and for the sake of the institution.

I understand that:

- All medical and Protected Health Information is confidential and I am to access and/or read records only insofar as my job requires it.
- Record content is to be treated impersonally and not discussed between workers except in the most private settings.
- Clinical records will be viewed by the patient only in the presence of the CEO, Medical Director, or physician in consultation with the medical provider.
- Information contained in records will not be divulged to any person without proper written authorization of the patient.
- This policy pertains to all medical and Protected Health Information about a patient. It also pertains to information about my co-workers.
- There will be no discussion of patient information with anyone not responsible for the patient's care. This includes my family and friends.
- I hereby affirm that I will not divulge, copy or otherwise communicate to unauthorized persons or firms information obtained through contact with patients or employees in the normal course of my employment or from documentation contained in medical records or other WESTERN STARK FREE CLINIC documents.
- I understand that my failure to comply with this provision will result in my immediate termination and that I may be liable to prosecution under Federal confidentiality laws.

\_\_\_\_\_  
Volunteer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff's Signature

\_\_\_\_\_  
Date