**ANN SILVERMAN COMMUNITY HEALTH CLINIC**
595 West State Street Doylestown, Pennsylvania 18901
Phone: (215) 345-2260 Fax: 215-489-7236 Email: freeclinic@dh.org

# VOLUNTEER APPLICATION

NAME: _____ BIRTHDATE (MONTH/DAY/*YEAR*): ___/_____/_____

ADDRESS:_____ CITY:_____ STATE:___ ZIP_____

HOME PHONE: _____ DAYTIME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____ ARE YOU AT LEAST 18 YEARS OLD? YES NO

**VOLUNTEER AREAS OF INTEREST (PLEASE CIRCLE)**

**PATIENT CARE (Must have current PA license or certification):**
PHYSICIAN CRNP/PA NURSE PHARMACIST SOCIAL WORKER

DENTIST DENTAL HYGIENIST DENTAL ASSISTANT OTHER: _____

**OTHER PATIENT CARE (REQUIRES ADDITIONAL TRAINING):** BILINGUAL INTERPRETER

**NON-PATIENT CARE:** CLERICAL DATA ENTRY PHARMACEUTICAL PROGRAM OTHER

If OTHER, PLEASE DESCRIBE YOUR AREA OF INTEREST: _____

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DAYS OF WEEK AVAILABLE: _____ TIME OF DAY AVAILABLE _____

NUMBER OF HOURS AVAILABLE PER MONTH: _____ ARE YOU RETIRED? YES NO

ARE YOU CURRENTLY EMPLOYED? YES NO If yes, OCCUPATION: _____

BUSINESS NAME: _____ WORK PHONE: _____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP: _____

PREVIOUS VOLUNTEER EXPERIENCE: _____

LIST ANY SKILLS THAT YOU WOULD LIKE CONSIDERED FOR YOUR POSITION: _____

_____ LANGUAGES, OTHER THAN ENGLISH: _____

ARE YOU ABLE TO PERFORM THE FUNCTIONS OF THE VOLUNTEER POSITION YOU ARE SEEKING WITH OR WITHOUT REASONABLE ACCOMODATIONS? YES YES, WITH ACCOMODATIONS NO

IF REASONABLE ACCOMODATIONS WOULD BE REQUIRED TO PERFORM YOUR VOLUNTEER SERVICE, PLEASE DESCRIBE HOW YOU WOULD PERFORM THE TASK AND WHAT ACCOMODATIONS YOU WOULD REQUIRE._____

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HAVE YOU EVER PLED GUILTY TO OR BEEN CONVICTED OF A CRIME, FELONY, AND/OR MISDEMEANOR SUMMARY OFFENSES, WHICH HAVE NOT BEEN EXPELLED OR APPEALED? YES NO

IS THIS A COURT DIRECTED COMMUNITY SERVICE PROJECT? YES NO If yes, provide a contact name and phone number for the person who is directing or supervising you.

NAME: _____ PHONE:_____

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**REFERENCE: Please provide one written reference, using the reference form below, from the person of your choice (not family).**

I _____ hereby authorize_____

NAME OF VOLUNTEER APPLICANT NAME OF PERSON PROVIDING THIS REFERENCE

to complete the reference form below in connection with my application to volunteer at Ann Silverman Community Health Clinic. I also consent to the release of whatever information is required to complete this form. I understand that this information is to aid Ann Silverman Community Health Clinic in selecting qualified volunteers and that all information provided will be kept confidential.

Date _____ Applicant's Signature _____

1. How long have you known this applicant? _____
2. How do you know this applicant? _____
3. Is the applicant self-motivated and does he/she follow through with their responsibilities? _____
4. What are the applicant's strengths? _____
5. What are the applicant's weaknesses? _____
6. Describe the applicant's ability to work with others. _____
7. Describe the applicant's dependability. _____
8. Describe the applicant's appearance/grooming. _____
9. Additional comments:

   _____

   _____

10. Would you recommend this person for the Ann Silverman Community Health Clinic volunteer program?

    Patient Contact YES NO Non-Patient Contact YES NO Either YES NO

Date _____ Reference Signature _____

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**<u>Please write a paragraph stating why you would like to volunteer for Ann Silverman Community Health Clinic.</u>**

_____

_____

_____

_____

_____

Date:_____ Name:_____

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**COMMITMENT TO CONFIDENTIALITY:** I, _____ understand my
PRINT YOUR NAME

obligation to maintain the complete confidentiality of any and all information in order to protect clients and their families, as well as all members of the Ann Silverman Community Health Clinic and Doylestown Hospital family from improper disclosure of information given in confidence, particularly when the information is related to the health, business or personal matters of the client, client's family, associates, volunteers, or members of the Board or Medical Staff.

I also understand that confidentiality must be maintained regardless of the source of the information, including but not limited to:

- the spoken word
- the medical record (client's chart)
- computerized or electronic records
- financial reports, statistical data, minutes of meetings, personnel files, or other records of the Doylestown Hospital or the Ann Silverman Community Health Clinic business

and that access to information and dissemination of information are subject to confidentiality standards. Violation of a person's right to confidentiality or inappropriate dissemination of confidential information is considered a breach of the Health Insurance Portability and Accountability Act of 1996 and of the policies of Ann Silverman Community Health Clinic and will be subject to immediate review and serious consequences, up to and including termination.

**ACCIDENTS/INJURIES:** If a person is injured while volunteering for the clinic, the incident must be immediately reported to the Executive Director of the Ann Silverman Community Health Clinic. All bills are first submitted to the injured person's primary insurance carrier. In appreciation of the volunteer's service, the clinic will pay any uncovered costs. I understand that I am not covered under Workmen's Compensation Insurance during my volunteer work with the Ann Silverman Community Health Clinic.

Date: _____ Signature: _____

**After completing and signing this application, please read carefully and sign:**

I have decided for my own personal reasons to volunteer my services to the Ann Silverman Community Health Clinic. In connection with these volunteer services I understand, acknowledge, and intend that:

1. If accepted by the Ann Silverman community Health Clinic as a volunteer, I agree to abide by all volunteer and clinic policies and procedures.
2. I affirm that all information provided on the application or in the application process is true and correct.
3. The services that I perform in connection with the Ann Silverman Community Health Clinic are freely donated by me and I do not expect to receive any compensation for these services.
4. I am fully committed and able to volunteer for at least one year. I agree to volunteer for a minimum of 3 hours twice a month for the first 3 months, and, thereafter, at least 3 hours per month for the remaining 9 months.
5. I have not been coerced in any way by Doylestown Hospital or the Ann Silverman Community Health Clinic to volunteer my services. Nor have I been offered any promise of advancement within either organization.
6. *For current Doylestown Hospital Associates*: The volunteer services that I perform will not occur during my regular working hours or scheduled overtime hours for Doylestown Hospital. In no way will the position I hold as volunteer for the Ann Silverman Community Health Clinic conflict or interfere with my position as a paid Associate of Doylestown Hospital.
7. I give permission to Ann Silverman Community Health Clinic to investigate any and all information concerning my application in order to determine my qualifications. This includes, but is not limited to, medical clearance, criminal background checks, employment and personal reference checks. Falsification of information provided in this application will result in non-admission or dismissal from Ann Silverman Community Health Clinic's Volunteer program.
8. I agree to be photographed by Doylestown Hospital for an ID badge and to have a PPD Tuberculin skin-test (or chest x-ray, if applicable).
9. I agree that any personal property carried by me from hospital premises, including my packages, briefcase, or any other hand luggage may be inspected by authorized personnel.

10. I agree to abide by all regulations and rules of Ann Silverman Community Health Clinic and Doylestown Hospital. I understand that, if placed, my placement will be subject to the conditions of any applicable introductory period established by Ann Silverman Community Health Clinic policies. I understand that this application and any other documents I have signed are not contracts of employment, and that any volunteer who is placed may voluntarily leave under proper notice, and may be terminated by Ann Silverman Community Health Clinic at any time for any reason.
11. In the event of resignation or termination, I agree to return all property of Ann Silverman Community Health Clinic or Doylestown Hospital loaned to me such as ID badges, books, etc.
12. My signature below indicates that I have read, understood and consented to the statements above. This authorization or a photocopy shall serve as consent for Ann Silverman Community Health Clinic to request information concerning my application.

DATE: _____ SIGNATURE: _____

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**CRIMINAL RECORD BACKGROUND CHECKS and CHILD ABUSE CLEARANCE**

All volunteers and employees of Ann Silverman Community Healthy Clinic are required to submit to a PA State Police Criminal Background Check, Child Abuse/ChildLine Clearance, and FBI Fingerprinting.

The **PA Criminal Background Check** is completed by Doylestown Hospital. The attached form must be returned with the completed volunteer application. The criminal background check will be completed by Doylestown Hospital and will occur only after your application is reviewed and you have completed orientation.

Documents explaining the procedure for obtaining the **Child Abuse/ChildLine Clearance and FBI Fingerprinting Clearance** are also attached. Note that you must attach the results of the hospital's Criminal Background Check to your application for the Child Abuse Clearance. There are fees that you must pay for both the Child Abuse Clearance and the FBI Fingerprinting Clearance. Please keep your receipts for these clearances. After completing 10 hours of volunteer work you may submit your receipts for reimbursement by the clinic.

When you receive the results of the Child Abuse and FBI Fingerprinting clearances, please submit the original clearance documents to the clinic.

Volunteers will not be placed in a specific assignment until all clearances are completed and either show a clear record or the results have been discussed with the prospective volunteer and a decision for acceptance made, on a case-by-case basis, by the Executive Director of Ann Silverman Community Health Clinic.

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## THE STEPS FOR VOLUNTEERING

Due to time delays for obtaining the proper clearances and PPD testing, the procedure for volunteering is:

1. Submit volunteer application and PA State Police Criminal Background check request form.
2. Attend orientation.
3. Obtain two-step PPD (or chest x-ray, if applicable). The two-step PPD takes 2 weeks. Obtain the first PPD at either at the clinic or your doctor's office, then return 48-72 hours later to have it read. Wait one week, and have the 2nd PPD. Wait 48-72 hours to have it read, either at the clinic or your doctor's office. Bring results to the clinic, if done at your doctor's office.
4. While awaiting PPD completion, obtain PA State Police Clearance and submit Child Abuse and obtain FBI Fingerprinting.
5. Submit clearance results to clinic.
6. After clearances are approved you will be assigned to a staff member for further orientation.

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## REQUEST FOR CRIMINAL BACKGROUND CHECK by DOYLESTOWN HOSPITAL

Last Name: _____

First Name: _____

Middle Name: _____

Maiden or Former Names / Aliases: _____

_____

Social Security Number: _____

Sex (circle one): MALE FEMALE

Race (circle one): AMERICAN INDIAN ASIAN BLACK HISPANIC WHITE

OTHER: _____

Date of Birth: _____

****This form must be completed, signed and returned with the Volunteer Application by all applicants.****

## Child Abuse History Clearance and FBI Fingerprint Criminal History Background Check

All volunteers and employees of Ann Silverman Community Healthy Clinic are required to submit to a PA State Police Criminal Background Check, Child Abuse/ChildLine Clearance, and FBI Fingerprinting. The PA Criminal Background check is completed by Doylestown Hospital. Below are instructions for completing the Child Abuse Clearance and FBI Fingerprinting Clearance.

When you receive the results of your clearances, please bring the original clearance documents to the clinic. You may not volunteer until these clearances are completed and approved by the Executive Director. There are fees that you must pay for both the Child Abuse Clearance and the FBI Fingerprinting Clearance. Please keep your receipts for these clearances. After completing 10 hours of volunteer work you may submit your receipts for reimbursement by the clinic.

### Pennsylvania Child Abuse History Clearance Instructions

Please read the instructions prior to completing the application. All information must be completed in full. This information must be provided to the best of your knowledge and belief. If necessary, attach additional pages.

1. Type or print clearly and neatly in ink Section I only. The address must be the applicant's current home address. The form asks for all previous names, addresses, and household members since 1975.
2. The application must be signed.
3. Enclose a $10.00 Money Order for each application. No cash or personal checks accepted. The mailing address is on the actual form in the top left text box.
4. Do not send any postage paid return envelopes.
5. The application should be placed in a business-sized or larger envelope prior to mailing.
6. Check one block for Purpose for Clearance: check the Volunteer Block only.
7. A copy of your PA Criminal Record Check results obtained within the past year from Doylestown Hospital/Ann Silverman Community Health Clinic must be attached. If you are not a Pennsylvania resident, you must also attach a copy of your FBI results obtained within the past year. This block should not be checked for anyone volunteering in schools.

Clearance results will be mailed to you within 14 days from the date that the clearance is received in the DPW office. There will be no replacements after 90 days. Failure to comply with the above instructions will cause considerable delay.

### FBI Fingerprint-based Criminal History Background Clearance

Current employees or volunteers of Doylestown Hospital may transfer their clearance without having to obtain a new FBI clearance. This follows the same procedures already in law under the Child Protective Services Law.

We are using the Cogent Systems to process fingerprint-based FBI record checks. The fingerprint based background check is a multiple step process. You must first register with the Cogent Systems Web site at https://www.pa.cogentid.com/index_pde.htm. The website also provides detailed instructions on how and where to obtain the FBI fingerprint based record check. The cost of obtaining the FBI criminal record check is $33.