

ANN SILVERMAN COMMUNITY HEALTH CLINIC

595 West State Street ♦ Doylestown, PA 18901

Phone: (215) 345-2260 ♦ Fax: (215) 489-7236 ♦ Email: pmdh-freeclinic@pennmedicine.upenn.edu

VOLUNTEER APPLICATION

NAME: _____ EMAIL ADDRESS: _____

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

HOME PHONE: _____ CELL PHONE: _____

ARE YOU AT LEAST 18 YEARS OLD? ☐ YES ☐ NO BIRTHDATE (MONTH/DAY/YEAR): ____ / ____ / ____

VOLUNTEER OPPORTUNITIES AT THE CLINIC (Please check ☒ areas of interest)

PATIENT CARE (Requires current PA license or certification):

☐ PHYSICIAN ☐ CRNP ☐ NURSE ☐ SOCIAL WORKER

☐ DENTIST ☐ DENTAL HYGIENIST ☐ DENTAL ASSISTANT ☐ OTHER: _____

PATIENT CARE FACILITATOR (Requires competency assessment and additional training):

☐ BILINGUAL INTERPRETER (SPANISH) ☐ ELIGIBILITY PROCESSOR

NON-PATIENT CARE (Requires prior experience or transferable knowledge):

☐ RECORDS MANAGEMENT ☐ PHARMACEUTICAL ASSISTANCE APPLICATIONS

☐ CLERICAL ☐ OTHER: _____

Availability: Days of week: _____ Time of day: _____ Number of hours per month: _____

Are you currently employed? ☐ Yes ☐ No ☐ Retired If yes, occupation: _____

Previous volunteer experience: _____

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 accommodations? ☐ Yes ☐ Yes, with accommodations ☐ No

If reasonable accommodations would be required to perform your volunteer service, please describe what accommodations you would require. _____

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 or a requirement for your education? ☐ Yes ☐ No

Please state why you would like to volunteer at Ann Silverman Community Health Clinic:

VOLUNTEER APPLICATION CHECKLIST

The following requirements **must be completed prior** to attending a volunteer orientation:

_____ Submission of completed and signed volunteer application and reference form.

_____ Documentation of a negative TB skin test (PPD) or negative for TB chest x-ray within the last 6 months. The clinic will administer your TB skin test, if you have not had one done prior, at your orientation.

_____ Documentation of annual vaccination against influenza between October 1st to April 30th. This is required in order to volunteer during the influenza season listed above.

_____ If you are volunteering in a clinical capacity, documentation of current active or volunteer status professional licensure/certification.

_____ Completion of PA DHS Act 153 Background Clearances for Volunteers packet.

- PA State Police Criminal Record Check – go to <https://epatch.pa.gov/home> and fill out the “New Volunteer Record Check”
- PA Child Abuse History Clearance –go to www.compass.state.pa.us/CWIS. Create a new account and follow the directions carefully.
- FBI Fingerprint Clearance*–go to www.indentogo.com/locations/pennsylvania or www.uenroll.indentogo.com .

*If you have lived in Pennsylvania for 10 straight years, you may forego the FBI check and obtain a notarized affidavit instead. This can be completed at orientation.

UNDERSTANDING AND AGREEMENT BY VOLUNTEER APPLICANTS

My signature on this form is evidence that I have decided for my own personal reasons to volunteer my services to the Ann Silverman Community Health Clinic (ASCHC) and that I understand, acknowledge, and agree to the following:

1. To abide by all volunteer and clinic and hospital policies and procedures.
2. I affirm that all information provided during the application process is true and correct.
3. The services that I perform in connection with the ASCHC are freely donated by me and I do not expect to receive any compensation for these services.
4. I will not volunteer during my regular working hours or scheduled overtime hours for Penn Medicine Doylestown Hospital if I am currently employed by Penn Medicine Doylestown Hospital.
5. I give permission to ASCHC 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 ASCHC's volunteer program.
6. I understand my obligation to maintain the complete confidentiality of any and all information in order to protect applicants and patients of the ASCHC and their families, as well as all members of the ASCHC and Penn Medicine Doylestown Hospital family from improper disclosure of information given in confidence.
7. If a person is injured while volunteering for the ASCHC, the incident must be immediately reported to the Executive Director of the ASCHC. All bills are first submitted to the injured person's primary insurance carrier. In appreciation of the volunteer's service, the ASCHC will pay any uncovered costs. I understand that I am not covered under Workman's Compensation Insurance during my volunteer work with the ASCHC.
8. I agree to return my ID badge to the ASCHC upon my resignation or termination from ASCHC.
9. 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 ASCHC to request information concerning my application.

DATE: _____ SIGNATURE: _____

CLINIC USE ONLY:

Application Reviewed and Accepted ____/____/____ Reference Received and Accepted ____/____/____

Interview/Recommendation to Proceed ____/____/____ PPD/Radiographs Cleared ____/____/____

All Required Clearances Received ____/____/____ Orientation Checklist Completed ____/____/____

Assigned to _____ Effective ____/____/____

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VOLUNTEER APPLICANT REFERENCE FORM

Using this reference form, please request a written reference from a person of your choice (not family). Responses can be mailed directly to the clinic at the above address, Attn: Volunteer Coordinator.

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? _____
4. Does he/she follow through with their responsibilities? _____
5. What are the applicant's strengths? _____
6. What are the applicant's weaknesses? _____
7. Describe the applicant's ability to work with others. _____
8. Describe the applicant's dependability. _____
9. Describe the applicant's appearance/grooming. _____
10. Would you recommend this person for the Ann Silverman Community Health Clinic volunteer program?

Patient Contact: ☐ YES ☐ NO

Non-Patient Contact: ☐ YES ☐ NO

11. Additional comments:

Date _____ Reference Signature _____