



bringing hope and health to our community...

Dear Interested Provider,

We are happy you are considering becoming a part of the team at Salem Free Clinics! If not for caring individuals like you, we couldn't provide vital medical care to the uninsured in our community. We want to make sure that you have a great experience exploring a volunteer role with us at Salem Free Clinics. Below you will find helpful information and next steps as you consider if this is a good fit for you at this time:

- A regular commitment of at least once a month is required in order to be an active volunteer with our clinic. We would love to be able to schedule the same time each month and will work with you and your schedule to find a day(s) of the month that will work with your availability. If your availability is not suited for a regular schedule, we have a web-based scheduling system where you can sign yourself up on days that work for you and when the clinic has staffing.
- We invite you to an informational meeting and tour of the clinic prior to processing your application. To schedule, please contact Jennie Pino at jenniep@salemfreeclinics.org or call 503-990-8772 ext. 3.
- Prior to submission, please make sure all the application is filled out completely, required document photocopies are included and that it is signed and dated where needed.
- Please note that if you are interested in volunteering with our partner site in Dallas, you can check the box on the application and we will direct your application after it has been processed.

Once your completed application is received and processed, we will contact you to let you know and invite you to come and shadow a provider. After this privileging step is completed, we will begin the process to secure your malpractice insurance through the Federal Tort Claims Act (FTCA), which is offered at no cost to you or the clinic. It can take 4-6 weeks to complete and you will not be able to volunteer until that time. However, if you have your own insurance and wish to begin sooner, you can provide us a copy of the insurance coverage for our files by attaching it to application or turning it in separately. The last step will be to discuss your schedule and organize a clinic around your availability.

Thank you for taking the time to consider joining this excellent volunteer team that works diligently to meet needs in the lives of our valued community members. We wouldn't exist without people like you! We count ourselves fortunate that you would consider sharing your time and expertise at Salem Free Clinics.

Sincerely,

Jennie Pino
Volunteer Coordinator
503-990-8772 x3



<p style="text-align: right;"><i>Office Use Only:</i></p> <p>Type of Provider: _____</p> <p>Privileging Date: _____</p>

SALEM FREE CLINICS
 1300 Broadway NE #104, Salem, OR 97301
 Phone: 503-990-8772
 Fax: 503-990-8774
 www.SalemFreeClinics.org

Volunteer Application – Acute care/Specialty care provider

Salem Free Clinics (SFC) exists to provide quality, compassionate health care at no cost to the uninsured in our community as an expression of Christ's love

Where are you interested in volunteering?

- Broadway (main location) Polk Community Free Clinic – Dallas, OR

GENERAL INFORMATION:

Name: _____ Date of Birth: _____
 Address: _____ City _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Email Address: _____

Employer: _____ Address: _____
 Job Title: _____ Years Worked: _____ Work Phone: _____
 Job Duties: _____

EMERGENCY CONTACT INFORMATION:

Spouse (if married): _____ Phone: _____
 Other Contact Name: _____ Relationship: _____
 (H): _____ (C): _____ (W): _____

BACKGROUND INFORMATION:

In what other organizations have you served as a volunteer?

Have you ever been convicted of a crime? No Yes

If yes, please explain:

VOLUNTEER INFORMATION:

How did you hear about SFC?

Are you affiliated with a faith community? No Yes If so, Where:

Do you speak another language? No Yes If yes, what language(s):
 Are you willing to be an interpreter? No Yes

CREDENTIALING INFORMATION:

Do you have your own private mal-practice insurance? No Yes

Have you had any mal-practice claims against you in the past 10 years? No Yes

If yes, please explain:

School of Medicine: _____

Date of Graduation: _____

Dates of Internship: From: _____ To: _____

Type of Internship: _____

Dates of Residency: From: _____ To: _____

Type of Residency: _____

Dates of Fellowship: From: _____ To: _____

Type of Fellowship: _____

Please attach copies of:

- License for area of expertise
- Drivers License or other government issued photo ID
- DEA
- BLS, ACLS, PAL's or other accreditation

The information I have provided may be verified, if necessary, by contacting persons or organizations named in this application, or by contacting any person or organization that may have information concerning me, or by conducting a criminal background check. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to support Salem Free Clinics mission, values, policies and procedures. In signing this agreement I recognize that I am putting myself under the authority of the SFC Board of Directors and leadership of the clinic.

Signature: _____ Date: _____

TB Screening & Hep B Vaccination

A PREREQUISITE TO THE PROCESSING OF THIS APPLICATION IS THAT YOU HAVE COMPLETED THIS FORM AND ALL THE SCREENINGS/VACCINATIONS AS INDICATED BELOW.

As part of the TB Screening & Hep B Vaccination policy of Salem Free Clinics the following are the requirements for each type of application (please check the box that applies for your application):

Providers: TB test that is current within 9 months of this application and completion of the Hep B information below.

- I certify that my PPD skin test was **negative** as of _____ (date performed). I currently have no symptoms of active TB disease. (Attach test information with application.)
- I certify that I am PPD skin test **positive** and have had (or am currently undergoing) appropriate evaluation and/or treatment for my positive skin test. I currently have no symptoms of active TB disease.
-
- I certify that I have been vaccinated for Hepatitis B. The series of three injections was completed on or about _____. (Date or approximate date of completion.)
- I am in the process of having the Hepatitis B series of three injections completed. The anticipated date of completion is _____. (Provide verification to clinic when completed.) I understand that I cannot have direct patient care until this process is completed, but can work behind the scenes work in the clinic on non-clinic days.
- I have not had the Hepatitis B series of three injections and choose not to participate in the treatment series.

Signature

Date

Printed Name

CRIMINAL HISTORY SCREENING CONSENT FORM
Staff and Volunteers

INSTRUCTIONS:

Please answer all questions on this form. Do not leave any areas blank. If information requested does not apply to you, write "NA" for not applicable or the word "none."

By providing your social security number, we will use it to ensure that we do not misidentify you. *Giving your social security number on this form is voluntary.* If for any reason we are unable to complete this background check, we may ask you to provide additional means of identification. Your social security number will be used only as stated above. State and federal laws protect the privacy of your records.

COMPLETE THE FOLLOWING INFORMATION: (please print clearly)

Print Name: _____

Date of Birth (MM/DD/YR): _____ Gender: Female Male

Social Security/Resident Alien Number (OPT.): _____ Place of Birth: _____

Address: _____

Street City State Zip

How long have you lived in Oregon (in years)? _____

If less than seven (7) years, list all states where you have previously lived and during which years: _____

Maiden/all other names previously used: _____

Authorization to Release Information
(Release from Liability and Waiver)

To any law enforcement agencies, civil records authorities and SFC: I authorize you to release to SFC any and all information and civil or criminal records naming me, including all entries where I am named as being arrested, as a suspect, as being cited for any crime, violation, infraction or offense, or as otherwise involved or named in any report by any member agency of your organization. The information that I have provided is accurate to the best of my knowledge and may be verified, if necessary by contacting persons or organizations named in this application, or by contacting any person or organization that may have information concerning me, or by conducting a criminal background check. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to hold harmless SFC and employees and volunteers thereof.

Applicant Signature: _____ Date: _____

Please do not submit this document electronically. Print it off and mail it to the address located at the top of the application or deliver in person to the clinic with your signature.