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 Aelix Fowler at aelix@salemfreeclinics.org or call 503-990-8772 ext.7.

- 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,

Aelix Fowler
Volunteer Coordinator
503-990-8772 x7

Office Use Only:
Volunteer Role : _____
License Date: _____
Credentialing Date:_____
Privileging Date: _____
FTCA Complete: _____

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 malpractice insurance? ☐ No ☐ Yes

Have you had any malpractice 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 practice
- ☐ Drivers License or other government issued photo ID
- ☐ DEA Registration
- ☐ BLS, ACLS, PALS 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 & Hepatitis B Vaccination Policy

PRIOR TO APPLICATION SUBMISSION, PLEASE COMPLETE THE PORTION(S) OF THIS FORM AS INDICATED BELOW AND ATTACH SCREENING RESULTS (REQUIRED FOR ALL) AND VACCINATION RECORDS (IF APPLICABLE).

TB Screening & Hepatitis B Vaccination policy requirements for Salem Free Clinics by application type:

General Volunteer (non-licensed): TB test that is current within 9 months of this application. Results must be attached to application prior to submission. It is not required that you fill out the Hep B Vaccination portion.

Other Professional Volunteer (licensed): TB test that is current within 9 months of this application. Results must be attached to application prior to submission. Completion of the Hepatitis B Vaccination section with attached documentation if applicable.

TB Screening

☐ 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.

Hepatitis B Vaccination

☐ 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/USCIS# (Optional): _____ 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.