SALEM FREECLINICS

bringing hope and health to our community…

Dear Interested Dentist,

Thank you for your interest in becoming a volunteer for Salem Free Clinics. If not for caring individuals like you, we couldn't deliver dental care to the uninsured in our community. Below you will find information about current volunteer opportunities as well as next steps as you consider if this fits the volunteer experience you are seeking:

- At this time most of our dentists are agreeing to see a specific number of our patients per month in their office free of charge. This is an efficient and easy process to implement. However, we do have a full set up for dentists to volunteer at the clinic if this is more convenient. You can bring your own assistants to help or utilize our volunteers.
- If you are interested in utilizing our space, we would love to show you around the clinic and answer any questions you may have. To schedule, please contact Judi Imig at judi@salemfreeclinics.org or call 503-990-8772.

Once we receive your application to volunteer, we will begin the process to secure your malpractice insurance through the Federal Tort Claims Act (FTCA), which is free to all of our providers. 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 we will begin organizing a dental clinic based on your availability.

Thank you for taking the time to consider joining this amazing team of volunteers. Our clinics are volunteer run, so 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
Salem Free Clinics

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

Volunteer Application – Primary Provider
(Dentist)

The Salem Free Clinics (SFC) exists to provide quality health care at no cost to the poor, the uninsured, and the underinsured children and adults in our community as an expression of Christ's love.

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

NOTE: Processing your application through the Federal Tort Act Coverage of Free Clinic Volunteer Health Care Professionals (malpractice insurance) may take up to four (4) weeks. Please be patient. We will let you know as soon as all the information has been returned to us. You will need to wait to volunteer with us solo until we receive confirmation of your coverage or provide us with a copy of your personal coverage for your file if you choose.

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):

- ☐ General Volunteer: TB test that is current within 9 months of this application.
- ☐ Other Professionals/Providers and all staff working in dental: 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.