



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 necessary 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. Informational meetings are available Fridays at 1pm or 2pm and generally take 30 minutes. To schedule, please contact Jennie Pino at [jenniep@salemfreeclinics.org](mailto:jenniep@salemfreeclinics.org) or call 503-990-8772 ext. 3. Other meeting times are available if Fridays don't work for your schedule.
- Prior to submission, please make sure all the application is filled out completely and that signatures are included 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 you will be contacted by staff within about two weeks to let you know that your application has been processed 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 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 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. 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

Where are you interested in volunteering?  
 Broadway (main location)  
 Polk Community Free Clinic – Dallas, OR

Volunteer Application – Primary Provider  
 (Doctor, Dentist, Chiropractor, Psychiatrist, Psychologist, Nurse Practitioner, P.A., etc.)

FTCA sent: \_\_\_\_\_.

*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):

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.***