THE MERCY MINISTRIES

Mercy Medical Clinic • Mercy Dental Clinic • Mercy University

Office Use ONLY (Clinical Director)	
☐ Immunization Rec. Received	____
☐ Reference Check	____
☐ GVHCP Packet Received	____
☐ GVHCP Approved	____
☐ License Verified	____

Clinical Volunteer Application

Name: _____ DOB: _____ Today's Date: _____

Phone: _____ Email: _____

Local/ Mailing Address: _____

Profession / Title: _____ Area of specialty: _____

License #: _____ Certification #: _____

Affiliated Practice/Institution: _____

In case of Emergency, please contact: _____ Phone: _____ Relationship: _____

How did you hear about Mercy Health Center?

- ☐ Current Volunteer
- ☐ Friend/Family Member
- ☐ Church
- ☐ Medical/Dental Practice
- ☐ Website
- ☐ Other: _____

What is your faith identity? (i.e. Christian, Jewish, No Faith, etc...) _____

What house of worship do you attend, if applicable? _____

Why do you want to volunteer with us? _____

_____

_____

Is there a particular patient population you most enjoy working with or have the most experience providing care for?

_____

Please answer the following questions and explain affirmative responses on back or on additional sheet.

Have you had your license to practice medicine suspended, revoked, or restricted?	☐ Yes ☐ No
Have you had disciplinary measures taken against you by the Board of Nursing/Board of Medical Examiners?	☐ Yes ☐ No
Have you had your clinical privileges at any health care facility deemed suspended, restricted, or revoked?	☐ Yes ☐ No
Have you ever had disciplinary measures taken against you at a health care facility?	☐ Yes ☐ No
Has your DEA ever been restricted, suspended, or revoked?	☐ Yes ☐ No
Have you ever been convicted of a felony?	☐ Yes ☐ No

Which clinic shift(s) best fits your schedule? Please circle your most available time(s).

Monday	8:30 am – 12:00 pm	1:00pm – 4:00 pm
Tuesday	8:30 am – 12:00 pm	1:00pm – 4:00 pm
Wednesday	8:30 am – 12:00 pm	
Thursday	8:30 am – 12:00 pm	1:00 pm– 4:00 pm
Friday	8:30 am – 12:00 pm	1:00 pm– 4:00 pm

Ideally, how often would you like to volunteer?

- ☐ Weekly
- ☐ Every other week
- ☐ Monthly
- ☐ Every other month
- ☐ Other: _____

"So in everything, do to others what you would have them do to you, for this sums up the Law and the Prophets." Matthew 7:12 (NIV)

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HIPAA Volunteer Confidentiality Agreement

I acknowledge that during the course of performing my assigned duties for The Mercy Ministries, I may have access to, use, or disclose confidential health information. I hereby agree to handle such information in a confidential manner at all times during and after my volunteer service and commit to the following obligations.

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties
B. I will request, obtain, or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish my assigned duties.
C. I will take reasonable care to properly secure confidential health information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password-protected screensaver in order to prevent access by unauthorized users.
D. I will not disclose my personal passwords to anyone, without the express written permission of my department head, or record or post it in an accessible location and will refrain from performing any tasks using another's password. I understand that as a volunteer in a place that provides health care, the use and disclosure of patient information is governed by the rules and regulations established under HIPAA (the Health Insurance Portability and Accountability Act of 1996) and related policies and procedures of The Mercy Ministries: The Mercy Medical Clinic, Mercy Dental Clinic, and Mercy University. Therefore, with regard to patient information, I commit to the following additional obligations.
    1. I will use and disclose confidential health information solely in accordance with the federal and clinic policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.
    2. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to the appropriate supervisor using the reporting procedure provided.

I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to the appropriate disciplinary action, up to and including, termination of the volunteer agreement.

Signature _____ Printed Name _____ Date _____

Toombs County
Office of the Sheriff

Georgia Bureau of Investigation
Georgia Crime Information Center
Consent for Criminal History Information

I hereby authorize **Mercy Medical Clinic and Foundation, Inc** to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

FULL NAME – include middle and maiden names if that applies:

Address: _____ City _____ State _____ Zip_____

Sex _____ Race _____ Date of Birth _____ Social Security Number _____

Signature _____ Date _____

Signature verified by me this ___ day of _____, 20____.

Notary: _____ *SEAL*

This history is needed for **Employment with Medical (elderly, etc)** (Purpose Code N).

Toombs County Sheriff's Department use only:

Criminal Record on File- See Attached ____

No Record Found ____

GCIC Operator Signature _____ Date: _____