GOOD NEWS CLINICS

VOLUNTEER INFORMATION & AUTHORIZATION FORM

DATE: _____ LANGUAGES SPOKEN: _____

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE_____ COUNTY_____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

TIMES AVAILABLE: Monday:____AM____PM Tuesday:____AM____PM

Wednesday:____AM____PM Thursday:____AM____PM Friday:____AM____PM

DEPARTMENT PREFERENCE: ANY____ ADMINISTRATION____

MEDICAL____ DENTAL____ PHARMACY____ COUNSELING____

GOOD NEWS CLINICS VOLUNTEER POLICY

As a volunteer at Good News Clinics, (initial below):

_____ I will volunteer for a duration of at least 3 months.

_____ I will provide information for and authorize a background check.

_____ I will donate $20 to Good News Clinics to offset the cost of the background check.

_____ I will be accountable for all commitments and show up regularly and on-time.

_____ I will provide advance notice if unable to make it in for a scheduled shift.

_____ I will not contact providers outside the clinic unless initiated by provider.

_____ I will not ask for free medical advice.

_____ I will respect patient confidentiality.

_____ I will always use caution when speaking with a patient so that any personal information cannot be heard by others.

_____ I will not repeat or disclose any patient information or administrative information that I observe, hear or read while volunteering at Good News Clinics. Confidential information includes patients' and donors' names, address, all personal information including medical, dental, and pharmacy services.

Signature: _____ Date: _____