



## 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: \_\_\_\_\_