



1600 W Country Club Blvd
Elk City, OK 73644

Volunteer Interest Form

Today's Date: _____

Full Name: _____

Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

Email Address: _____

Cell Phone Number: _____

Area(s) of Interest:

- | | |
|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Diagnostic Lab Work |
| <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Spiritual Health / Chaplain Team |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Biblical Counseling / Mental Health |
| <input type="checkbox"/> Medical Student | <input type="checkbox"/> Prayer Team |
| <input type="checkbox"/> Nurse / CNA | <input type="checkbox"/> Translation Team |
| <input type="checkbox"/> Medical Assistant | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Meal Provision (for our volunteers) |
| <input type="checkbox"/> Pharmacy Technician | <input type="checkbox"/> Medical Reception / Guest Services |

Please describe any relevant training or experience for your area of interest: _____

Are you licensed? Yes / No (Please attach a copy or provide your License or NPI number):

How did you hear about New Life Medical Clinic? _____

Do you have pervious volunteer experience? [] Yes [] No

If yes, name of organization: _____

From (dates) _____ to _____ Who was your supervisor or Team Leader?

_____ Phone: _____

Are you currently a student? [] Yes [] No School _____

What is your major field of study? _____

Do you speak any non-English languages? Yes / No Language(s)? _____

Are you familiar with medical or basic anatomical vocabulary in that language? Yes / No / Possibly

VOLUNTEER CONFIDENTIALITY ACKNOWLEDGEMENT AND AGREEMENT

During the course of your volunteer activity, you may have access to information which is confidential. It may not be disclosed except as permitted or required by law and in accord with New Life Clinic (NLC) policies and procedures. In order for NLC to properly care for patients and engage in successful business planning, certain information must remain confidential. Improper disclosure of confidential information may cause irreparable damage to NLC. Confidential information includes, but is not limited to:

1. Medical and certain other personal information about patients.
2. Medical and certain other personal information about our volunteers.
3. Medical staff records.
4. Reports, policies and procedures, marketing or financial information.

By signing this Confidentiality Acknowledgement, I acknowledge and agree that:

1. I will only access business information for which I have legitimate business purpose as approved by a duly authorized representative of NLC.
2. I am obligated to and will hold confidential information in the strictest confidence and will not disclose the information to any person or in any manner which is inconsistent with this agreement.
3. I will print information only when necessary for a legitimate purpose and when approved by a duly authorized representative of NLC. I am accountable for this information until it is destroyed.

I HAVE READ AND UNDERSTAND THIS CONFIDENTIALITY AGREEMENT.

Volunteer Signature Date

Printed Name

WAIVER and RELEASE of LIABILITY

This Waiver and Release of Liability (“Agreement”) is a legal and binding agreement which, when signed, will permanently limit your ability to hold the New Life Clinic (NLC) liable for injuries or losses you may cause or sustain as a result of your decision to perform, without compensation, volunteer tasks (“Services”) for the NLC.

Volunteers performing services regardless of the location of the services and regardless of whether the volunteer is identified as being associated with the NLC, the volunteer must complete and sign this Waiver and Release of Liability prior to beginning their voluntary service with NLC.

The New Life Clinic is a private institution. I am a current or prospective volunteer at NLC performing services in the _____ (Department or Team)

I [print your name] _____ freely choose to act as a volunteer and not as a NLC employee and perform services which include the following physical or mental activities such as walking, standing, sitting, bending, lifting, reading, speaking, hearing, etc.: I agree to inform myself about the potential dangers of the services and any precautions I should take and any information that the NLC may provide. Despite precautions, accidents, sickness and injuries can and will occur. I understand that the services may be dangerous and that I may be injured and/or lose or damage personal property as a result of performing the services. Should there be a needle stick involved in the care of our patients, the needle stick protocol will be initiated immediately (see nursing protocol – needle stick).

I fully and completely assume all risks related to the activity including death, injury, illness or loss from accidents, theft of or damage to personal belongings. All costs for follow up care will be borne by the volunteer.

I agree with the above terms and conditions of this Waiver and Release of Liability.

Signature of Volunteer Date

Printed Name

Background Check / Volunteer Disclosure

New Life Clinic (NLC) screens all volunteers through a public national sex offender registry to determine whether the applicant poses a risk of harm to the vulnerable patients we may serve, i.e. children, the elderly, and individuals with disabilities.

Individuals that have been charged with, indicted for, or pled guilty or no contest to a misdemeanor and/or felony crime involving a minor, the elderly and/or individuals with disabilities, will not be eligible to volunteer at NLC until a one-on-one interview and thorough investigation is completed by the appropriate NLC leadership team. Once completed, the appropriate NLC leadership team will make a final decision on whether the prospective volunteer is eligible to volunteer at the New Life Medical Clinic.

Any individual that has been required to register as a sex offender in any jurisdiction is not eligible to volunteer at New Life Medical Clinic due to the probability of children being present.

Please Note: For the safety and protection of our volunteers, all volunteers at NLC must have at least two volunteers present when working with patients, with the exception of doctor/patient situations of the same gender. Doctors and nursing volunteers must have a volunteer present when working with the opposite sex.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- 1) Have you ever been charged with, indicted for, or pled guilty or no contest to an offense (misdemeanor and/or felony) involving a minor, the elderly and/or individuals with disabilities?**
___ NO ___ YES

If YES, please explain:

- 2) Have you ever been required to register as a sex offender in any jurisdiction?**
___ NO ___ YES

I hereby acknowledge that I have read and understand the above statements and that my answers are true to the best of my knowledge.

Signature of Applicant Date PRINT FULL NAME

Please provide a copy of your Driver's License or Legal ID and your SS #

SS # _____

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Office Use Only

Background Check / Sex Offender Registry review performed on (date): _____

Performed by: _____