Good Neighbor Health Clinic and Red Logan Dental Clinic
70 North Main Street
White River Junction, VT 05001
(802) 295-1868

Community Volunteer Application

(For assignments that do not require prior medical/dental training)

Name: ____

First MI Last

Address: ____

Street Address or PO Box

____

Town, State, Zip Code

DOB: ___________

Flu Vaccine (Date) __________ TB Test (Date) _________Results_______

Covid Vaccine (Dates) ______ ______ ______ ______

Please attach a copy of Covid Vaccine record

Contact Information: Complete all and **check the best way** to contact you.

____ Email: ______________________________

____ Home Phone: _________________________

____ Cell Phone: ___________________________

Emergency Contact: In case of an emergency, please contact

Name: ___________________________ Phone: ______________________

Relationship: ______________________

What are the best days of the week and times of day for you to volunteer?
(One 2-hour session per month or more)

How did you become interested in becoming a volunteer at the clinic?

What type of volunteer work would you like to do at the clinic?

Please list any other volunteer or employment experiences that may be related to volunteering at the clinic:

Students, please give your age ____, expected year of graduation ____, and name of school ______________________

Have you ever been convicted or pled guilty or no contest (nolo contendere) to, or received probation, suspension, or deferred adjudication for a misdemeanor or felony involving moral turpitude (includes, but not limited to: dishonesty, fraud, deceit, theft, misrepresentation, deliberate violence, offense of a sexual, drug, or alcohol related offenses)?

Yes: _________ No: ________

References: We request that you provide names of two (2) references.
(No family member, please)

1. Name: ________________________________ Daytime Phone: __________________

   Address: ____

   Email: _________________________________ Relationship: ____________________

2. Name: _________________________________ Daytime Phone: __________________

   Address: ____

   Email: __________________________________ Relationship: ___________________

In being considered for a volunteer position at the Good Neighbor Health Clinic and Red Logan Dental Clinic, I agree that the clinic staff and any of the references provided may exchange information regarding my qualifications without incurring any liability. If accepted as a volunteer at GNHC and/or RLDC, I agree that I am making a commitment to serve and agree that I will: (Initial each)

____ Demonstrate behavior while interacting with other which includes: serving patients, families, visitors, and co-workers respecting each individual's dignity and and privacy and maintaining privacy health information.
____ Contact the clinic with as much advance notice as possible if I am unable to volunteer on my scheduled day.

Signature: ____________________________________ Date: ______________________

Thank you for your interest in volunteering with GNHC and RLDC.
We appreciate your community spirit and are eager to get to know you.

Please drop off or mail your completed application to
70 North Main St, White River Junction, VT 05001
Or email it to lisa@goodnhc.org

Revised: 2/15/2023

Good Neighbor Health Clinic (GNHC)
Red Logan Dental Clinic (RLDC)

PRIVACY/CONFIDENTIALITY STATEMENT

GNHC/RLDC employees, volunteers, officers, and contractors shall hold as absolute confidential all health information that may be obtained directly or indirectly concerning out patients.

Confidential/protected health information includes the following, whether in electronic, oral or paper form:

* **Items containing health information about a patient that reasonably could directly or indirectly identify the patient.**
* **Any information we receive or create relating to an individual's past, present, or future physical or mental health or condition, or the provision of or payment for health care provided to that individual.**
* **All patient information contained in patient records whether paper or electronic including but not limited to patient demographics (age, sex, address, date of birth, telephone number), appointment history or any medical or clinical information.**

Do not look up and/or share any patient information without a verifiable need to know. A "need to know" is defined as what information one needs to know in order to do their job. You should obtain, use, and share only the minimum amount of information necessary.

Do not use any patient information for your personal purpose (for example, looking up birth date or phone number).

Disclosure of protected health information to any unauthorized persons, including employees of GNHC/RLDC without a "need to know" is a breach of confidentiality. Any questionable activity identified by a patient, volunteer, or employee will be impartially investigated and appropriate responsive action will be taken.

The following are example of potential breaches:

* **Discussing patients or their illness in public places where the conversation may be overheard, Including telephone conversations.**
* **Publicly identifying patients, in spoken words or in writing.**
* **Leaving identifiable phone messages.**
* **Sharing a confidential password with unauthorized persons.**
* **Disclosing any patient's personal health information outside of GNHC/RLDC unless permitted by specific GNHC/RLDC policies.**

I have read and understand these expectations.

Name: _______________________________________

Signature: ____________________________________ Date: ______________________________

Revised 9/14/22