Good Neighbor Health Clinic
Red Logan Dental Clinic

Community Member Volunteer Instructions

Thank you so much for your interest in volunteering with Good Neighbor Health Clinics. Our ability to provide much-needed free medical and dental care to our neighbors rests entirely on a vibrant network of medical professionals and community volunteers who are willing to give their skills, time, and attention. We're delighted you want to be part of our team!

As a community volunteer, depending on your schedule, skills, and interests, you may be able to help us with any of our many needed tasks such as:

- Inventorying supplies
- Appointment confirmation calls
- Scanning files
- Caring for our facility
- Shredding documents
- Warmly welcoming patients
- Public outreach events

Attached to this instruction sheet are the **application**, **confidentiality form**, and **release form**. Once completed, please send **all** required documents to Volunteers@goodnhc.org.

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 volunteers@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: _____

Good Neighbor Health Clinics

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I have read and understand these expectations.

Name: _____

_____ _____

Signature Date

Good Neighbor
Health Clinics

Release for Photos to be Taken/Used

I authorize Good Neighbor Health Clinic to use my photograph and name to further their mission to educate the community about the ongoing work of and services provided by the Good Neighbor Health Clinic and the Red Logan Dental Clinic.

I understand that my photograph may be used in a wide variety of promotional materials including newsletters, flyers, posters, brochures, videos, advertisements, fundraising letters, annual reports, press kits and submission to journalists, websites, social networking sites and other print and digital communications.

Name:_____(Please print)

Signature:_____

Date:_____

Phone:_____

E-mail:_____

We will use your e-mail address only to contact you regarding use of photos.

Please include only those phone numbers and e-mail addresses at which we may safely leave you messages that identify Good Neighbor Health Clinic/Red Logan Dental Clinic and your connection to either of them.