Good Neighbor Health Clinic
Red Logan Dental Clinic

# Medical Professional 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 who are willing to give their skills, time, and attention as volunteers. We're delighted you want to be part of our team!

In order to provide care under our roof, all of our essential licensed volunteers have to be covered by our medical liability insurance through the federal government. This requires the following:

1. Application, Confidentiality, and Release form completion.
2. Credentialing (our staff verifies all credentials).
3. Privileging (Good Neighbor's Medical Advisory Committee approves practice privileges).
4. Deeming (we apply for medical liability coverage from HRSA).
5. Scheduling (recurring clinics at times that work for you).

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

This process naturally has a methodical pace. However, at the end of it all, we have another open clinic, more services for our neighbors, and more medical students learning from your care. We appreciate your patience through this process and are so excited to have you join us!

# Volunteer Application for Licensed Healthcare Provider

Good Neighbor Health Clinics

## CONTACT INFORMATION

First | MI | Last

Home Address

Employer

Work Address

Cell Ph | Work Ph

Home Ph | Email

SSN | Date of Birth

☐ Female ☐ Male ☐ Other ☐ Decline

Emergency Contact: In case of emergency, who would you like us to contact?

Name

Phone | Relationship

## PROFESSIONAL INFORMATION

☐ MD ☐ PA ☐ DO ☐ APRN ☐ RN ☐ DDS ☐ DMD ☐ DH Other

License/Cert VT # | Exp. Date

License/Cert NH# | Exp. Date

*if applicable*

DEA # | Exp. Date

NPI # | Exp. Date

FEIN # | Exp. Date

UPIN # | Exp. Date

Professional School | Graduation Year

Specialty (if any)

**Please provide 2 professional references: (from organizations not associated with GNHC)**

Name

City/St | Relationship

Email | Daytime Phone

Name

City/St | Relationship

Email | Daytime Phone

## VOLUNTEERING WITH US

**What professional services do you propose to provide?**

**When was your most recent clinical experience?**

☐ currently OR ☐ date

**How many clinics/month is the best match for you?**

☐ once/month ☐ twice/month ☐ weekly other ☐

**What day and time is best for you?** ☐ 1st choice ☐ 2nd choice

**Part of our mission is to mentor aspiring health care professionals. Do you have experience working with medical students? What is your approach to mentoring?**

**Please provide the following documents:**

____ Current Motor Vehicle Driver's License or other proof of identity
____ All active Professional License/s and Certificate/s
____ CV/Resume (or short biography including current professional status)
____ Current BLS Training Documentation
____ Immunization Records (including Covid-19)
____ Fitness for Duty Attestation (if retired)

**As a volunteer applicant at Good Neighbor Health Clinics I agree:** ***(please initial)***

_____ Clinic representatives and any of my references may exchange information regarding my qualification and I authorize the release of information to verify my credentials.

**If accepted as a volunteer at GNHC, I agree that I am making a commitment to serve and agree that I will:** ***(please initial both)***

_____ Demonstrate behaviors while interacting with others, which include: Serving patients, families, visitors, and co-workers, respecting each individual's dignity and privacy, and maintaining the confidentiality of health information.

_____ Contact the clinic with as much advance notice as possible if I am unable to volunteer on my scheduled day.

**I understand that failure to disclose full and truthful information on this application could result in denial of privileges.**

**Signature:** _____ **Date:** _____

***Thank you for your interest in providing vital health care to our neighbors!***

**Please return completed application and required documents:**
**email to Volunteers@GoodNHC.org**
**OR fax to 802-295-3600 (medical) OR fax to 802-359-1020 (dental)**
**OR mail to 70 North Main St, White River Junction VT 05001**

Good Neighbor Health Clinics

# Consent for Release of Information

Good Neighbor Health Clinics (GNHC) credentials all licensed volunteers prior to granting approval to practice at GNHC by the Medical Advisory Committee. Regional hospitals are delegated as credentialing organizations for this purpose.

Please sign this form to authorize release of this information.

I authorize

_____

_____

to release information to Good Neighbor Health Clinic (GNHC) to verify that I am fully credentialed with clinical privileges in good standing.

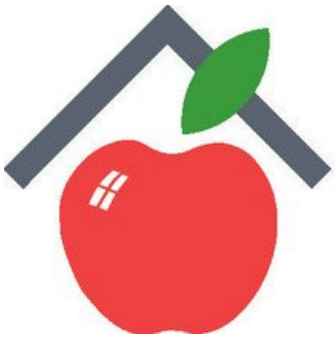
Applicant's Name _____

Applicant's Signature: _____

Date: _____

Thank you,
Management Team of GNHC

2023.05.23



Good Neighbor
Health Clinics

# PRIVACY / CONFIDENTIALITY STATEMENT

GNHC/RLDC employees, volunteers, officers and contractors shall hold as absolutely confidential all health information that may be obtained directly or indirectly concerning our 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 purposes (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 examples of potential breaches:

- Discussing patients or their illnesses 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 personal health information outside GNHC/RLDC unless permitted by specific GNHC/RLDC policies.

I have read and understand these expectations.

Name: _____

_____ _____

Signature Date

2023.05.23

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.