Neighborhood Clinic Volunteer Application

Medical Clinic

Thank you for your interest in volunteering to bridge the health equity gap!

ALL MEDICAL CLINIC VOLUNTEERS TO COMPLETE THIS SECTION

(*Except MultiCare residents. Please request resident application from volunteer@neighborhoodclinictacoma.org)

Please enclose a resume or curriculum vitae as well as a copy of any current licenses or other relevant certifications with this application.

1 - Name

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2 - Email

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3 - Preferred phone #

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4 - Cell phone # (if different than above)

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5 - Address

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6 - How did you find out about Neighborhood Clinic volunteer opportunities?

□ Colleague/friend □ NC Staff □ Current/Former Volunteer □ Social Media

□ Google/web search □ VolunteerMatch □ Other (who/what?):

7a - Are you fluent in any language other than English? Yes No If yes, which?

7b - Are you fluent in medical terminology for this language(s)? Yes No

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8 - If you hold any credential through the WA State Department of Health, we strongly encourage you (residents excluded) to sign up for the free Volunteer and Retired Providers (VRP) malpractice insurance provided through the Washington Healthcare Access Association (WHAA). We will gladly provide you the application or you can download it at https://goo.gl/GFkh7c . If you are eligible for VRP coverage but choose to decline it, please send documentation of your existing malpractice coverage which shows both the validity dates and that the policy covers you while you are volunteering specifically at Neighborhood Clinic. You will also be responsible for providing us with updates when any changes or renewals are made to your malpractice coverage.

Please check one:

_____ I will apply for the VRP malpractice coverage

_____ I decline VRP malpractice coverage. I understand I am responsible for verifying that my current malpractice covers my work at Neighborhood Clinic, and that I am responsible for providing Neighborhood Clinic with any changes or renewals to my malpractice coverage.

(see next page)

ALL PROVIDERS* AND NURSES TO COMPLETE THIS SECTION (MD, DO, NP, PA, RN, LPN)

(*Except MultiCare residents. Please request resident application from volunteer@neighborhoodclinictacoma.org)

Credential(s) and any additional certifications:

Specialties:

How long have you been practicing? WA Medical License #

NPI # DEA #

Providers and nurses: You have completed your section of this form. Please sign and date at bottom of page.

ALL CLINICAL SUPPORT VOLUNTEERS TO COMPLETE THIS SECTION (eg MA, CNA, EMT, Phlebotomist)

Certificates or Licenses Held:

Please provide copies of any certificates or licenses you hold related to your work in health care.

Clinical Support Volunteers: You have completed your section of this form. Please sign and date at the bottom of page.

ALL INTERPRETERS TO COMPLETE THIS SECTION

Language(s):

Certifications:

Do you currently work as a medical interpreter?

Please attach copies of any certifications you hold related to interpreting.

Interpreters: You have completed your section of this form. Please sign and date at the bottom of page.

ALL SOCIAL WORKERS and REFERRAL COORDINATORS TO COMPLETE THIS SECTION:

Credential(s) and any additional certifications:

Specialties:

How long have you been practicing? WA License #

Social Work/Referral Volunteers: You have completed your section of this form. Please sign and date at bottom of page.

ALL VOLUNTEERS TO SIGN AND DATE BELOW

My signature below indicates that the information I have provided is true and correct. I understand that Neighborhood Clinic requests a commitment of one shift per month for the medical clinic. I understand that volunteers are asked to make an initial commitment of one year of service, and I will communicate with the volunteer coordinator about my availability should I be unable to fulfill such commitment. I understand that I will be expected to attend an orientation prior to my first volunteer shift. I agree to keep Neighborhood Clinic up to date as to my current contact information and address.

Date: Signature: