

**Licensed Volunteer Application**

Please Print:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Most communication is via email)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred phone: \_\_\_Cell \_\_\_Home \_\_\_Work

Social Security number (Only if malpractice coverage needed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Information

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position(s) you are volunteering for:

\_\_\_Clinician (MD,DO,NP,PA, PT, RT)\* \_\_\_Patient Care (Nurses, MA's etc)\*

\_\_\_Lab Tech\* \_\_\_Receptionist

\_\_\_Social Worker\*/Intake \_\_\_Dietician\*/Diabetes Educator\* \_\_\_Registration \_\_\_Host/Hostess (volunteer meals)

\_\_\_Pharmacist/Pharmacy Tech\* \_\_\_Other

\_\_\_Office Support Staff \_\_\_PAP

Current Licenses (Please attach a copy):

*Please note that a current license is only necessary for clinicians*.

\_\_\_MD\*/ DO\* \_\_\_NP\* \_\_\_PA \* \_\_\_RN\* \_\_\_LPN\*

\_\_\_MA\* \_\_\_RPh\* \_\_\_RD\* \_\_\_SW\* \_\_\_RT\*

\* Indicates free volunteer malpractice insurance is available from the State of WI or FTCA.

Professional School Attended:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Graduation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please include a copy of your diploma if available. (Only if requesting malpractice insurance).

Special Expertise (knowledge of computers, foreign language, grant writing, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Available to Volunteer:

\_\_\_Evenings during clinic \_\_\_Daytime \_\_\_\_Other

Personal Information

I am: \_\_\_Employed \_\_\_Unemployed \_\_\_Retired \_\_\_Student @\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need any special accommodations? \_\_\_Yes \_\_\_No

Do you have any medical conditions we should be aware of? \_\_\_Yes \_\_\_No

If yes please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note**: All volunteers are responsible for ensuring their vaccinations are up to date. **Must be vaccinated for COVID if volunteering during clinic nights.**

**Please answer the following questions and attach details for any YES response.**

Have you ever been convicted of a criminal offense? \_\_\_Yes \_\_\_No

Have you ever been notified by a state licensing board of charges against you? \_\_\_Yes \_\_\_No

Have any of your licenses or certificates to practice ever been restricted, revoked, suspended, limited, surrendered or canceled or has there been any other disciplinary action against your licenses or certificates?

\_\_\_Yes \_\_\_No

Have your hospital staff privileges ever been limited or removed? \_\_\_Yes \_\_\_No

Has the DEA ever withdrawn your DEA number or warned you? \_\_\_Yes \_\_\_No

Malpractice Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

National Provider Identification Number (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEA Number (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note**: All Clinicians MUST have malpractice coverage. Free coverage for volunteers is available

through the FTCA.

**I, the undersigned, understand and agree to the following as a volunteer of the Open Door Clinic:**

I grant the Open Door Clinic the right obtain a “consumer report” about me from a consumer reporting agency for volunteering purposes. A “consumer report” is a background screening report that may contain information regarding my criminal history. It may bear upon my character, general reputation, personal characteristics, and/or mode of living.

I am aware that I will come in contact with confidential information and that it is my responsibility to maintain this confidentiality in accordance with the ODC policies and procedures. I further understand that in the case of breach of confidentiality, I should expect termination from the volunteer program.

I will not hold the Open Door Clinic liable for any adverse condition or injury resulting while serving or representing this organization.

* I grant the Open Door Clinic the right and unrestricted permission to use any and all media (photos, video) of me for illustration, promotion, art, advertising or any purpose whatsoever without restriction. **Circle one: Yes No**

I certify that: (1) The above information is complete and correct, and (2) I understand and agree with the confidentiality statement.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OPEN DOOR CLINIC VOLUNTEER APPLICATION

Please provide 2 references:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do they know you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do they know you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give the Open Door Clinic permission to contact the above references.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Open Door Clinic, Inc.***

***Confidentiality and Nondisclosure Agreement***

**Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print first and last name)

I understand that in my relationship with *The Open Door Clinic, Inc*. I will have access to information not generally available or known to the public. I agree that such information is confidential information that belongs to *The Open Door Clinic. The Open Door Clinic’s* confidential information includes but is not limited to: patient, customer, member, provider, group, physician, employee, financial and proprietary information, whether oral, observed or recorded in any form or medium. I agree that information developed by me, alone or with others, may also be considered confidential information belonging to *The Open Door Clinic*.

I will hold *The Open Door Clinic’s* confidential information in strict confidence and will not disclose or use it except as authorized by *The Open Door Clinic* and for *The Open Door Clinic’s* benefit.

I will not access confidential information for which I have no legitimate business need to know. Only designated volunteers/employees may release medical information with the proper written consent from the patient.

I understand that if I breach the terms of the Confidentiality and Nondisclosure Agreement, *The Open Door Clinic* may institute disciplinary action up to and including termination of service and/or association with The Open Door Clinic.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Federal Tort Claims Act**

**Release of Information for Open Door Clinic Volunteers**

In order for the Open Door Clinic to access and verify my educational background, professional qualifications and suitability for appointment, I hereby authorize the Open Door Clinic to make inquiries and consult with all persons, places of employment, education, malpractice carriers, State licensing boards, or other similar government and non-governmental entities who have or may have information bearing on my moral, ethical and professional qualifications and competence to carry out the privileges I have requested.

I consent to the release of information about my ability and fitness for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and authorize release of such information and copies of related records and/or documents to include only the requested information for verification.

I authorize the Open Door Clinic to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me sufficient to enable the Open Door Clinic to make such inquiries.

I release from liability all those who provide information to the Open Door Clinic in good faith and without malice in response to such inquiries.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Full Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Please return application via one of the following:

Email: [coordinator@chippewaopendoor.org](mailto:coordinator@chippewaopendoor.org)

Fax: 715-720-4656

Mailing address: 130 W. Central St.

Chippewa Falls, WI 54729