



serving the working uninsured

**CLINIC VOLUNTEERS**

Thank you for your interest in serving with us at Faith Family Clinic. Please complete the information below so we may better match your time and interests with our needs. **PLEASE PRINT**

Name \_\_\_\_\_ Today' Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Home Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Cell Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work \_\_\_\_ - \_\_\_\_ - \_\_\_\_

E-Mail \_\_\_\_\_ Other Language \_\_\_\_\_

Would you like to receive the email newsletter, *Faith Family Matters*? \_\_\_\_Yes \_\_\_\_No

Emergency Contact \_\_\_\_\_ Relation: \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer \_\_\_\_\_

School \_\_\_\_\_ Degree Program \_\_\_\_\_ Status/Year \_\_\_\_\_

**Professional Credentials**

\_\_\_\_MD \_\_\_\_DO \_\_\_\_DDS - Specialty \_\_\_\_\_

\_\_\_\_PA \_\_\_\_NP \_\_\_\_RN \_\_\_\_LVN \_\_\_\_EMT/Paramedic Specialty \_\_\_\_\_

\_\_\_\_PhD \_\_\_\_LPC \_\_\_\_LCSW \_\_\_\_LMSW \_\_\_\_MSW \_\_\_\_BSW Other \_\_\_\_\_

\_\_\_\_Accounting/Bookkeeping \_\_\_\_Office Management/Supervision \_\_\_\_Receptionist \_\_\_\_Billing/Coding

**Volunteer Interests**

- \_\_\_\_ Medical Provider
- \_\_\_\_ Medical Assisting/Patient Care
- \_\_\_\_ Administration/Receptionist
- \_\_\_\_ Counseling (list degree above)
- \_\_\_\_ Case Management (credentials above)
- \_\_\_\_ Translator - Language \_\_\_\_\_
- \_\_\_\_ Prayer Partner/Encourager
- \_\_\_\_ Nutrition &/or Fitness
- \_\_\_\_ Church Health Coordinator
- \_\_\_\_ Patient Education
- \_\_\_\_ Community Health Fairs
- \_\_\_\_ Other \_\_\_\_\_

**Available Day(s) and Hours**

Monday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm
Tuesday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm
Wednesday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm
Thursday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm
Friday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm
Saturday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm
Sunday	____ 8:30am-Noon	____ 1:00pm - 5:00pm	____ 5:00pm-9:00pm

Clinic Preference (Check one or both): \_\_\_\_Westside \_\_\_\_Northeast Frequency: \_\_\_\_\_

Westside Professional Building  
700 South Zarzamora St., Suite LL1  
San Antonio, TX 78207  
210-431-7380 office  
210-431-2773 fax

info@faithfamilyclinic.org  
www.FaithFamilyClinic.org

Northeast Medical Center  
8711 Village Dr., Suite 310  
San Antonio, TX 78217  
210-653-1511 office  
210-653-1941 fax



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### Recommended Immunizations

Faith Family Clinic recommends that all volunteers receive the Hepatitis B vaccination series and Tuberculosis screening by intra-dermal injection. You may obtain these from your doctor or county health department.

Please provide Faith Family Clinic with a copy of results or notice of administration of vaccinations to be placed in your volunteer file.

### CPR/AED

Being CPR/AED trained is a vital part of volunteering in a medical setting. It is also important knowledge to have in your personal life. Cardiopulmonary resuscitation can save a person's life if started within minutes of cardiac and/or respiratory arrest. If you have this training or are interested in obtaining this training please notify the Office Manager.

### CONFIDENTIALITY POLICY

The staff and volunteers of Faith Family Clinic take pride in our work and deeply respect the confidentiality of information to which we are entrusted. All information and records pertaining to patients, volunteers and staff are private and confidential and only authorized persons who must refer to such information as a business necessity shall have access to them. This information is kept in strict confidence! Please do not discuss clinic business or personal information in the presence of unauthorized persons. For more information please visit [www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy).

Confidentiality is a serious concern and violations of this policy will result in corrective action to include the possibility of separation of employment and/or the inability to continue to work as a volunteer for this organization.

I am aware that Health and Safety Codes for the State of Texas provide for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

Criminal Background Processed (Date) \_\_\_\_\_ Completed (Date) \_\_\_\_\_

Confirmation Letter Sent (Date) \_\_\_\_\_  Approved  Denied

\_\_\_\_\_  
Executive Staff Authorization Date

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## Consent for Criminal Background History & Or Driving Record Check Authorization/Waiver/Indemnity

Each staff member or volunteer who is to be screened must sign an authorization/waiver/indemnity form, giving approval for the Agency and the Volunteer Center to perform the criminal background & or driving records search.

I HEREBY GIVE PERMISSION FOR FAITH FAMILY CLINIC TO OBTAIN INFORMATION RELATING TO MY CRIMINAL HISTORY RECORD THROUGH THE VOLUNTEER CENTER. THE CRIMINAL HISTORY RECORD & OR DRIVING RECORD, AS RECEIVED FROM THE REPORTING AGENCIES, MAY INCLUDE ARREST AND CONVICTION DATA AS WELL AS PLEA BARGAINS AND DEFERRED ADJUDICATIONS. I UNDERSTAND THAT THIS INFORMATION WILL BE USED, IN PART, TO DETERMINE MY ELIGIBILITY FOR AN EMPLOYMENT/VOLUNTEER POSITION WITH THIS ORGANIZATION. I UNDERSTAND THAT AS LONG AS I REMAIN AN EMPLOYEE OR VOLUNTEER HERE, CRIMINAL HISTORY RECORDS & OR DRIVING RECORDS CHECKS MAY BE REPEATED AT ANY TIME. I UNDERSTAND THAT I WILL HAVE AN OPPORTUNITY TO REVIEW THE DATA COLLECTED A PROCEDURE IS AVAILABLE FOR CLARIFICATION, IF I DISPUTE THE RECORD AS RECEIVED.

I, THE UNDERSIGNED, DO, FOR MYSELF, MY HEIRS, EXECUTORS AND ADMINISTRATORS, HEREBY REMISE, RELEASE AND FOREVER DISCHARGE AND AGREE TO INDEMNIFY FAITH FAMILY CLINIC, AND EACH OF THEIR OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS HARMLESS FROM AND AGAINST ANY AND ALL CAUSES OF ACTIONS, SUITS, LIABILITIES, COSTS, DEBTS AND SUMS OF MONEY, CLAIMS AND DEMANDS WHATSOEVER, AND ANY AND ALL RELATED ATTORNEYS' FEES, COURT COSTS, AND OTHER EXPENSES RESULTING FROM THE INVESTIGATION OF MY BACKGROUND IN CONNECTION WITH MY APPLICATION TO BECOME A VOLUNTEER/STAFF MEMBER.

CRIMINAL BACKGROUND CHECK

DRIVER RECORDS CHECK (FFC will authorize)

Name:

Street Address:

City:  State:  Zip:

Social Security Number:  Date of Birth:

Driver License #:  State:  Expiration Date:

Signature:  Date:

Dept Code to charge:

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