Licensed Volunteer Application

Applicant Name:	Title:
Shift applied for:	Date Applied:

Requirements for All Licensed Professionals

1. ☐ A copy of your resume or CV and this completed application
2. ☐ A copy of your driver's license or state ID
3. ☐ A copy of your professional license wallet ID
4. ☐ Three professional references
5. ☐ Self-completed health/immunization history form and:
   a. ☐ Documentation of TB Test or chest X-ray per PHD protocol
   b. ☐ Documentation of Flu Vaccine
6. ☐ Your signature on JCFC Patient/Records Confidentiality Statement
7. ☐ Your signature on JCFC Conflict of interest/Ethics statement
8. ☐ Your Signature on all JCFC Abuse Reporting Requirements
9. ☐ A copy of your certificate of malpractice insurance (if applicable)
10. ☐ For All Providers – Your truthful completion of and signature on the questionnaire to be used by our insurance carrier—Personnel data, policy and loss information.

Additional Requirements for Medical/Nursing Professionals (Mental Health Providers Exempt)

1. ☐ A copy of your DEA certificate (if applicable)
2. ☐ A copy of your CPR/BCLS/ACLS certification
3. ☐ A copy of your Board certification, if applicable
4. ☐ Documentation of MMR & Varicella Screening
5. ☐ Hepatitis B vaccination history (Infection Control Guidelines Form)
6. ☐ Documentation of TDaP immunization
7. ☐ Medical Exam clearing you for volunteer placement
8. ☐ Signature of NP/PA protocol document for NP/PA

I HEREBY CERTIFY THAT THE FACTS SET FORTH ABOVE ARE TRUE AND COMPLETE AND I AUTHORIZE THE JEWISH COMMUNITY FREE CLINIC TO INVESTIGATE ANY AND ALL OF THE STATEMENTS I HAVE MADE.

Signature/Title:___________________________________ Date: ____________________

Provider Information

Basic Info

First Name:	Last Name	
Street:	City:	Zip:
Home Phone:	Other Phone:	
Fax:	Email	
Certifications:		
Occupation:	Employer/School:	

Skills and Experience

Languages: ☐ English ☐ Spanish ☐ Other:

What kind of a commitment can you make? ☐ 6 months ☐ 1 year ☐1 year plus

Medical Professionals – please check all clinics you are available:

☐ MON 9:30am-12:30pm ☐ MON 5:30pm-8:30pm ☐ TUES 3:00-6:00pm

☐ THURS 5:30pm-8:30pm ☐ Other Hours: ______________________

Mental Health Providers – please indicate the days and hours you are available:

☐ MON ______________ ☐ TUES ______________ ☐ WED ______________

☐ THURS ______________ ☐ FRI ______________

Why are you interested in volunteering at the JCFC?

How did you hear about us?

Please let us know if you need special accommodation to perform the volunteer work:

Relevant Work Experience

Job Description	**Date**	**Employer Name and Location**

References

Please list three professional references:

Name and Title	**Phone**	**Email**
1.		
2.		
3.		

Emergency Contact

Name:	Relationship:
Phone:	Other Phone:
Address:	

Please read and sign:

I have answered all the questions above and will continue to answer all questions truthfully and to the best of my ability. I understand that if I give false information, I will not be accepted (or allowed to continue) as a JCFC volunteer.

I further understand that as a JCFC volunteer, I must (1) comply with all policies and procedures—including maintaining full client confidentiality; (2) fulfill the responsibilities of the position and time commitment; and (3) work in ongoing consultation with the Volunteer Coordinator.

______________________________ ______________________________

Signature Date

QUESTIONNAIRE FOR USE BY PROGRAM BETA MALPRACTICE INSURANCE

The following questions apply to all licensed healthcare providers. If any answered "yes", supporting documentation must be included with the application.

1. Have you ever been involved in a malpractice claim, suit, or incident either directly or indirectly?

Yes • No *If yes, complete the attached claim information sheet*

2. Has any insurance carrier ever declined, cancelled, refused to renew, restricted or surcharged your professional liability insurance?

Yes • No *If yes, give details*

3. Have you ever been convicted/entered a "no contest" plea to a crime?

Yes • No *If yes, give details*

4. Have you ever been diagnosed or treated for alcoholism, narcotic addition or mental illness?

Yes • No *If yes, give details*

5. Do you have any personal health problems, which might affect your practice of medicine?

Yes • No *If yes, give details*

6. Have you ever been investigated by a state or federal regulatory body?

Yes • No *If yes, give details (including dates)*

7. .Has your professional license or permit or narcotic license ever been suspended, revoked, restricted, surrendered or placed under probation?

Yes • No *If yes, give details (including dates)*

8. Have you ever had any hospital privileges suspended, revoked, restricted, reduced, proctored or modified?

Yes • No *If yes, give details (including dates and names of hospitals)*

9. Has any physician or patient ever filed a complaint of any kind against you?

Yes • No *If yes, give details*

Please attach documents which disclose information material to risks not addressed in this application.

POLICY AND LOSS INFORMATION:

Please provide all professional and general liability policy information for the past five years, beginning with your current policy.

Policy Term	Insurer	Limits	Deductibles	Premium	Claims/Occurrences	Retroactive Date

Are you aware of any incidents, circumstances, or occurrences that have taken place since the proposed retroactive date, which may result in claims which have not been reported to another carrier? **• Yes • No** If yes, please provide details via attachment.

ATTACHMENTS:

The following information must be submitted with this application before coverage can be offered to you as a volunteer at the Jewish Community Free Clinic:

1. Loss information for the past ten years with a recent valuation date, including number of claims, indemnity paid and reserved, expense paid and reserved, and total incurred. (list Hospital Professional Liability and General Liability separately.)
2. For claims incurred in excess of $50,000, provide a brief description including allegations, status, and assessment of exposure to your facility.

REPRESENTATIONS, AUTHORIZATION AND RELEASE:

The applicant represents that the above statements and facts are true, and that no material facts have been suppressed or misstated. Completion of this form does not bind coverage or obligate the Authority to offer it.

The applicant agrees to cooperate with the Authority in implementing an ongoing program of loss control, and will allow the Authority to review and monitor such programs as the applicant undertakes in managing its professional and general liability exposures.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish the Authority and its agents or representatives and any and all information requested which may relate to insurability under the policy and, further, authorizes the release of all such information by the Authority as required by law to any governmental agency, or professional society or association.

Further, the applicant releases and agrees to hold harmless the Authority, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association, from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for coverage, not withstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

SIGNATURE OF THE VOLUNTEER APPLICANT FOR MALPRACTICE INSURANCE COVERAGE BY THE JEWISH COMMUNITY FREE CLINIC THROUGH THE BETA PROGRAM

Signature of volunteer applicant:____

Print Name and Title:____

Date:____

Program BETA Risk Management Authority

CLAIM INFORMATION FORM

NOTE: All questions must be answered completely

NAME OF PATIENT	
ALLEGATION	
YOUR RELATIONSHIP TO PATIENT (i.e. attending physician, surgeon, assistant surgeon, consultant, etc.):	
DATE OF OCCURRENCE	DATE REPORTED
LOCATION OF OCCURRENCE	
INSURANCE CARRIER	
ADDITIONAL DEFENDANTS	

CLAIMS STATUS: •□ OPEN •□ CLOSED (DATE CLOSED____/____/________) If closed, indicate:

a. Method of closing: •□ Dismissed □•Settled □•Judgement

b. Amount of settlement or judgement: $_________________

DESCRIBE YOUR CARE AND TREATMENT OF THE PATIENT (use additional space on the next page). Your narrative must provide adequate clinical detail to allow proper evaluation. Please include the following information:
Condition and Diagnosis at Time of Incident

b. Dates and Description of Treatment Rendered
c. Condition of Patient Subsequent to Treatment
d. Copies of Patient(s) Chart(s) and Operative Report(s)

I understand information submitted herein becomes part of my application as submitted.

SIGNED____ DATE_________________

NARRATIVE OF CLAIM

HEALTH/IMMUNIZATION HISTORY

Annual TB Tests are required (or evidence of negative chest X-ray with past prophylactic treatment with INH and no evidence of active TB currently.)

Volunteer providers must be in adequate health to carry out the duties they are required to perform, free from communicable disease or other disability that might adversely affect patients. Please complete and sign.

Description of regular duties as a volunteer at the Jewish Community Free Clinic:
Relevant Health History (illnesses, injuries or disabilities that may affect your ability to perform basic functions of the job):
Needs or limitations in performing job functions described above:

Immunizations

Date of TB Test (Required for All Providers including Mental Health):	
If positive, action taken:	
Date of Flu Vaccine (Required for All Providers including Mental Health):	
Date of last TDaP Shot (Mental Health Providers Exempt):	
Date of MMR (Mental Health Providers Exempt):	Or, date of immunity test:
Date of Varicella (Mental Health Providers Exempt)	Or, date of immunity test:
Date of HepB series (Mental Health Providers Exempt):	Or, date of immunity test:
Date of Medical Exam (Mental Health Providers Exempt):	

JCFC USE ONLY:	
Director Signature	Date

INFECTION CONTROL GUIDELINES: FOR THE PROTECTION OF HEALTH CARE WORKERS. These guidelines apply to all individuals working at The Jewish Community Free Clinic.

"Universal Precautions" must be followed by all health care workers.
According to the Centers for Disease Control: All blood and body fluids should be considered potentially infectious for HIV, Hepatitis B and other blood borne pathogens. Protective barriers to be used include gloves, masks and protective eye wear when potentially contacting blood or body fluids.

The following exposure categories outline guidelines for Hepatitis B vaccination:
CATEGORY I TASKS: Hepatitis B vaccination is REQUIRED for every person performing category I tasks. Category I tasks are procedures or other job related tasks that involve inherent potential for mucous membrane or skin contact with blood, body fluids or tissues, or a potential for spills or splashes.
Category I personnel include: MD's, PA's NP's RN's, DDS's, laboratory personnel, hygienists, dental assistants, community health workers, assistant community health workers, maintenance personnel, and acupuncture.

CATEGORY II TASKS: Hepatitis B vaccination is unnecessary for people in this category. Category II tasks involves no exposure to blood, body fluids or tissues. The normal work routine involves no exposures, although situations can be hypothesized under which anyone, anywhere, might potentially be exposed. Persons who perform these duties are not called upon as part of their employment to perform or assist in emergency medical care or first aid.
Category II personnel include: Clerical staff, receptionists, counselors, social workers, interpreters, toy and book volunteers, and administrative staff.
All Medical/Nursing personnel, who could be reasonably anticipated as the result of performing their duties to face contact with blood and other potentially infectious materials must be vaccinated for Hepatitis B Virus.

Please check one of the following:
☐I understand The JCFC policy as it relates to Hepatitis B vaccination.
☐I will schedule an appointment by (date)______________and bring written verification.
☐I have already received the vaccination and will provide written verification.
☐I have developed the anti-body for Hepatitis B and therefore do not require the vaccination. I will provide written verification.

____
Signature Date

POLICY ON CONFIDENTIALITY OF ALL MEDICAL RECORDS

The confidentiality of all medical records, including alcohol and drug abuse patient records maintained by the Jewish Community Free Clinic is protected. The Jewish Community Free Clinic may not disclose any information identifying a patient as an alcohol or drug user, unless: The patient consents in writing; the disclosure is allowed by a court order; or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Suspected violations of confidentiality laws may be reported. Federal law and regulations do not protect any information about a crime committed by a patient at the Clinic or against any person who works for the Clinic or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

In California, failure to maintain client information as confidential is considered a violation of privacy. Volunteers of the JCFC are subject to the same requirements and laws regarding confidentiality as employed staff.

Basic principles of confidentiality:

1. All information divulged by the patient to anyone at the JCFC is held in the strictest of confidence; patients of the JCFC are guaranteed this protection by California law.
2. The volunteer should not communicate confidential information to anyone except *relevant* staff of the JCFC.
3. Relevant discussions regarding patients between staff of the JCFC should take place only in appropriate areas where other patients and uninvolved staff won't overhear.
4. Violations of these principles could result in termination of any volunteer of the JCFC.

I, the undersigned, acknowledge that I have received a copy of this form and have read, understood, or have had the above summary information on confidentiality explained to me as attested to by my signature below. All information is to be held in the strictest of confidence. Failure to comply with this law will result in termination from my volunteer position.

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Signature Date

MANDATORY REPORTING OF CHILD ABUSE

In order to prevent the abuse of children, the State of California has enacted legislation requiring certain individuals to report known or suspected instances of child abuse.

Mandatory Reporters:

Health practitioners, including psychologists and licensed social workers, are mandated reporters of child abuse. Non-health practitioners and other volunteers (including clerical staff and other on-site volunteers) are expected to inform their supervisor or other mandated reporter when abuse is suspected. Common signs of abuse may include: the nature of the physical injury, the location on the body, the repetitious injuries and/or verbal report. Child abuse includes: Physical abuse, psychological/emotional abuse, sexual abuse, and neglect. Any suspected abuse must be reported to the child protective agency as soon as possible by telephone; and a detailed written report must be prepared and sent within 36 hours of receiving the information concerning the incident. The reporter is immune from civil or criminal liability for the report.

I ____________________________________, hereby attest that I understand my obligation to report instances of child abuse as required by California Penal Code Section 11165-11174, and will fulfill this obligation.

____

Signature   Date

MANDATORY REPORTING OF ELDER ABUSE

The State of California protects elders and dependent adults from physical and financial abuse. Common forms of abuse may include: physical abuse, abandonment, isolation, financial abuse, or neglect.

MANDATORY REPORTERS:
Persons responsible for care or custody of an elder or dependent adult, such as administrators, supervisors, licensed staff of a facility that provides care or services for elder or dependent adults, elder or dependent adult care custodian, health practitioners, employees, a county adult protective services agency or a local law enforcement agency are mandated reporters.

Reports of abuse shall be made to the adult protective services agency or the local law enforcement agency. If the conduct involves criminal activity, it may be immediately reported to the appropriate law enforcement agency. No mandatory reporter shall be subject to any sanctions for making a report.

NON-MANDATED REPORTERS:
Anyone who has the knowledge or reasonably suspects that other types of elder abuse are being inflicted, even though reporting may not be mandatory, may voluntarily report the incident to the county adult protective services agency, to prevent further endangerment and assure the well-being of the elder or dependent adult.

INFORMATION REQUIRED TO BE REPORTED:
A telephone report of a known or suspected instance of elder or dependent adult abuse includes: the name of the reporter, the name and age of the elder or dependent adult, their current whereabouts, the names and addresses of family members or any other person responsible for the elder or dependent adult's care, if known, the nature and extent of the elder or dependent adult's condition, the date of the incident, and any information that led that person to suspect elder or dependent adult abuse.

SANCTIONS FOR FAILURE TO REPORT ABUSE:
Failure to report physical abuse, abandonment, isolation, financial abuse, or neglect of an elder or dependent adult, is a misdemeanor. Any mandated reporter who fails to report abuse, where that abuse results in death or great bodily injury, is punishable by not more than one year in a county jail or by a fine of not more than five thousand dollars ($5,000), or by both a fine and imprisonment.

Received and acknowledged.

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Signature Date

DOMESTIC VIOLENCE REPORTING

POLICY: Any licensed health care practitioner volunteering/employed in a health facility is required to make a report if he/she provides medical services to a patient whom he/she knows or reasonably suspects is (1) suffering from any physical injury inflicted by another by means of a firearm, and/or (2) suffering from any physical injury inflicted upon the person through assault or abuse.

PROCEDURE:
Upon suspicion that a patient may be suffering from domestic violence, the clinician should attempt to ask specific questions relating to the suspected abuse.

The patient's safety must be the primary focus. The provider should inform the patient of the clinician's duty to report. The provider should ask if they want to be present during the telephone report to the police. The social worker can discuss in detail with the patient available choices for protection from further abuse. The clinician must address the risk of retaliation.

If the patient does not acknowledge abuse, but the clinician is still concerned, the clinician should attempt to offer some information and referrals about abuse.

Once the patient acknowledges abuse, with their permission, document a detailed history and physical examination. Documentation should include: chief complaint/history of present illness; past medical history, sexual history, medication history, and relevant social history. The physical examination should record precise details of findings related to abuse, including a neurological and mental status exam. Use a body map and take photographs if possible, to supplement written descriptions.

After examining the patient, the clinician and the social worker should collaborate in referrals and reporting. The social worker will be responsible for providing referrals sources and additional information on domestic violence. The clinician will be responsible for making a telephone report to law enforcement as soon as possible and following up with a written report within two working days.

I AGREE TO REPORTING REQUIREMENTS AS STATED ABOVE:

____

Signature Date

CONFLICT OF INTEREST/ETHICS

POLICY STATEMENT: The Jewish Community Free Clinic of Sonoma County expects all volunteers to adopt a high ethical standard of conduct in performance of their duties.

A conflict of interest exists when the actions or activities of a volunteer on behalf of the Jewish Community Free Clinic of Sonoma County include personal gain or advantage and have an adverse effect on the Jewish Community Free Clinic's interests. Conflicts of interest should be reported to the Executive Director, or Clinical Director.

1. To avoid any actual conflict of interest, or the appearance of a conflict of interest, a volunteer may not acquire any patient/client of The Jewish Community Free Clinic without the written consent of the Executive Director. With consent, the volunteer must agree to the following: They may not accept any fee for services; they are solely responsible for the patient/client; they must explain to the patient that the Jewish Community Free Clinic is no longer involved or responsible; and they must sign a waiver releasing the Jewish Community Free Clinic of all involvement.

2. No volunteer may represent themselves as a spokesperson for the clinic without prior approval.

3. All written materials, data, and client information, are the property of the Jewish Community Free Clinic and may not be used, except for the volunteer's clinic duties, without the express permission of the Executive Director.

4. A volunteer shall not accept gifts, services, or other favors from outside interests. In addition, a volunteer shall not accept gifts, services, or other favors where it might be inferred that such action was intended to influence or possibly would influence the volunteer in the performance of his/her duties at the Jewish Community Free Clinic.

RESPONSIBILITIES AND PROCEDURES:
When a potential conflict of interest situation exists, a volunteer is expected to submit a report in writing and meet with the Executive Director and/or the Clinical Director; the purpose of this meeting is to review the situation and arrive at an amicable solution. If no appropriate solutions can be reached, the volunteer will be asked to submit his/her resignation.

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Signature Date