Volunteers in Medicine
FREE CLINICS OF SOUTH JERSEY

Preferred Location

☐ **423 Route 9 North,**
Cape May Court House, NJ 08210 (609) 463-2846
email: volunteercmc@vimsj.org

☐ **3073 English Creek Ave**
Egg Harbor Township, NJ 08234
email: volunteerac@vimsj.org

Name: _____

Preferred Phone:_____ E-mail: _____

Address:_____

PLEASE CHECK ALL SKILLS THAT MAY APPLY

☐ Nurse	☐ Nurse Practitioner	☐ Data Entry	☐ Administrative
☐ Physician	☐ Physician Assistant	☐ Pharmacy	☐ Filing
☐ Receptionist	☐ Fundraising	☐ Maintenance/Handyman	☐ Interpreter

Computer programs I am familiar with: _____

Languages spoken: _____

Note: If your position requires licensure, you will be required to complete additional paperwork. Malpractice is provided for all clinical volunteers. *Lic #:*_____*Exp date:*_____

AVAILABILITY

Most volunteers commit to one 4 hour shift per week but others volunteer more or less. We understand you are a volunteer and take vacations, spend your winter in Florida, etc. We will do our best to accommodate your scheduling needs. Please note your availability and indicate your preferred day/time in the adjacent grid.

Would you prefer to work on call/ as needed? ☐ Yes ☐ No

___ Weekly ___ Twice/mo ___ Monthly ___ Other

	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Would you prefer to work on call/ as needed? ☐ Yes ☐ No

SIGNATURE AND DATE

_____ _____

(NAME) (DATE)

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Policy/ Procedure

VOLUNTEER CONFIDENTIALITY AGREEMENT

Once yearly, volunteers are asked to read the policy below regarding confidentiality and sign the statement of confidentiality indicating compliance and understanding.

POLICY

All individuals engaged in the collection, handling or dissemination of patient health information are specifically informed of their responsibilities to protect patient data and of the penalty for the violation of this trust. Proven violation of the confidentiality of patient information is cause for immediate termination of access to further data.

This policy is made known to all volunteers at the time of assignment and each volunteer indicates understanding of this policy through a signed statement at the time of assignment, kept with the volunteer records.

CONFIDENTIALITY STATEMENT:

I understand and agree that in the performance of my duties as a volunteer at Volunteers in Medicine, I must hold patient information in strict confidence. I understand that any violation of the confidentiality of this information will result in a transfer to another assignment or I may be asked to end my volunteer service.

Date: _____ Signature:_____

Please make any corrections to your personal information (listed above).

Emergency Contact(s)

Name: Phone # Relationship

1. _____

2. _____