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

Name: ____

Preferred Phone: ______________________ E-mail: ______________________

Address: ____

City: ____

PLEASE CHECK ALL ROLES 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 licensed clinical volunteers. *If applicable, is your license active in NJ? Yes ___ No _____*

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			

SIGNATURE AND DATE

______________________________ ______________________________

(NAME) ***(May require background checks.)*** (DATE)

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VOLUNTEER/EMPLOYEE CONFIDENTIALITY AGREEMENT

POLICY

Respecting the right to privacy is a basic element of this Volunteers in Medicine organization. Information about a patient/client, volunteer, board member or employee acquired in the conduct of the Clinic's business will be collected only by proper means, restricted to that which is relevant, used only for the required business purpose, and maintained in a manner which will protect its confidentiality. All statutory requirements with regard to the privacy of such information shall be strictly followed. Except as required by law, no information shall be released without permission. *Please refer to Policy Manual for more detailed statement.*

CONFIDENTIALITY STATEMENT:

I understand and agree that in the performance of my duties as a volunteer/employee at Volunteers in Medicine I must keep all patient information strictly confidential and adhere to all HIPAA regulations. I understand that any violation of the confidentiality of this information will not be tolerated.

Date: _____________ Print Name: ____

Signature:____

Emergency Contact(s)

Name: Phone # Relationship

1. ____

2. ____