MEDICAL VOLUNTEER APPLICATION

Please complete this form to volunteer with CCHS during the Covid-19 National Pandemic.

Upon completion of the application, please email the completed form, along with your picture ID to **COVID19Volunteers@christchs.org**

First name: ________________________ Last name: ____________________ Title:____________

Street: ____

City: _________________________ State: ________________________ Zip: __________________

Primary phone: _____________________________Alternate phone:__________________________

Email address: ____

Emergency Contact Name and Number: ____

Additional Information: (Make NA if not applicable to you)

Gender:______Date of birth:____________________SSN:___________________________________

Medical Title:_____________________________ Specialty: __________________________________

Employer: ______________________________________

School and Year Graduated ____________________________

License Number and State: __________________________

NPI Number: ______________________________________

As a volunteer member of the workforce at Christ Community Health Services, I authorize CCHS to obtain a NPDB query using the information I have provided in this application. I further agree to release from liability CCHS for their acts performed in good faith and without malice in connection with this application. This release shall be cumulative and in addition to any other applicable immunities provided by law for medical care review activities.

- Please ask your current employer to provide a statement attesting to your competence if you are a professional listed: MD, DO, NP, PA, RN, LPN, CMA, DDS, DMD, RDH, RDA, or other such clinical service provider. This can be emailed to **COVID19Volunteers@christchs.org** or, if your employer prefers to print and sign, it can be included with your return.

Please submit a copy of your government issued ID (DL or passport) when returning this application

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Christ Community™
HEALTH SERVICES

Confidentiality STATEMENT FOR NON-EMPLDYEES (VOLUNTEERS)

I, ______________________will not disclose any information about patients or the medical care they receive at Christ Community Health Services, Inc. I understand and agree that I must hold any patient information in confidence. I have an ethical responsibility to protect patients' privacy. Information regarding patients must not be released, disclosed, or discussed either inside or outside the work area. There are Laws, both state and federal, safeguarding patient records and assigning penalties for the release of confidential information without patient authorization. I understand that intentional or voluntary violation of patient confidentiality may result in punitive action, including possible restriction from work area, fines and/or imprisonment. I also agree that any personal/private information concerning CCHS employees to which I may have access will not be released or discussed either inside or outside the center. Furthermore, I will not under any circumstance copy or disclose business information or the work product of the company for a non-authorized use.

I understand that I have a duty to report any breaches of confidentiality or information security, whether inadvertent or intentional, whether by me or someone else, to my immediate Supervisor or to the Privacy and/or Security Officer to help mitigate any problems caused by such breach. I understand that my obligation to maintain the confidentiality of CCHS patients does not end if my relationship with CCHS is terminated.

I understand and agree that in the performance of my duties for CCHS, during off duty hours, and even after termination of my relationship with CCHS, I will not reveal or discuss confidential patient or business information with anyone unless authorized by CCHS to do so.

I have read the confidentiality agreement.

Signature____ Date: _____________________________

Participation Agreement

We are privileged to have a community of physicians dedicated to helping us serve our community of need with compassion, quality, and professionalism. We welcome you to the Christ Community Health Services and would like to share some practices and principles that help guide all of us here at the Christ Community Health Services as we work together.

I agree that I render these health care services voluntarily, without compensation or the expectation or promise of compensation. This acknowledgement and agreement have been made before rendering any services.

I agree to report to the appropriate persons any incidents or injuries in which I am involved with during my volunteer service. I understand that my service as a volunteer is covered up to the limits specified by the center's insurance program and I hereby waive any claim against the center except as specified herein.

I certify that the statements I have made in this application are true and accurate.

Volunteer Signature ___________________________________Date _________________________