



Barry Community Free Clinic

Volunteer Database

Date: _____ Dr./ Mr. / Mrs. / Ms. (Circle)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: (Street) _____ (City) _____ (Zip) _____

Home Phone: () _____ - _____ - _____ Date of Birth: _____ / _____ / _____

E-Mail Address: _____

Emergency Contact Person (Name/Phone) _____

Church Affiliation _____

Work Experience: _____

Current Employment:

Occupation: _____ Employed At: _____

Phone#: _____

Clinic Function to be trained for: (To Be Completed by Staff)

Eligibility: Y / N

Nursing: Y / N

Doctor: Y / N

Copy of Credential and Picture I.D. required:

Drivers License: Y / N

Nursing License: Y / N

Physicians DEA License: Y / N

Physicians State License: Y / N

Barry Community Free Clinic Volunteer Credentialing and Confidentiality Form

Name: _____

Michigan License #: _____ (copy on file?) Y / N

Place of Employment: _____

Malpractice insurance through: _____

Universal Precautions Knowledge: Y / N

OSHA Inservice knowledge: Y / N

Last TB test _____ results neg _____ or _____

Hepatoxax? _____ Other _____

I understand that I am expected to follow established protocols for practice while volunteering my services at the Barry Community Free Clinic.

I understand that in the course of my volunteer service at the Barry Community Free Clinic, I may have access to confidential medical information concerning patients at the clinic. I understand that this information has been obtained and recorded for the purpose of medical treatment. I agree that I will use this information only for the purpose of my job responsibilities and that under no circumstances will I disclose any information about any clients at the Faith Community Free Health Clinic to any non-authorized personnel.

I agree if I have any questions about this policy, I will consult with the Clinic Director.

Signed _____ Date _____

Witness _____ Date _____

* Please make a copy of your license (s) to return with this form