SAN JOSÉ CLINIC

Patient Care Volunteer Application
(Healthcare Professionals)

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

Suffix (Jr., III, MD, etc): _____ Last 4 digits of SSN: _____ Date of Birth: _____

Minimum age: 18 years old

Business Phone: _____ Cell Phone: _____ Gender: ◯ Male ◯ Female

Fax Number: _____ Email Address: _____

Preferred Primary Contact Method: ◯ Business Phone ◯ Cell Phone ◯ Email Address

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Professional Speciality: _____

University/College attended: _____ Year of Graduation: _____

Retired: ◯ Yes ◯ No *If yes, in what year did you retire?* _____

Professional Liaison - *Upon receipt of your application, we will contact you or a designee to discuss arrangements. If applicable, please provide the name of someone who can act as a liaison between you and San José Clinic.*

Contact Name: _____ Position: _____

Daytime Phone: _____ Email Address: _____

Emergency Contact Information

Contact Name: _____ Relationship: _____

Daytime Phone: _____ Cell Phone: _____

Employment Information - *Please include 5 years of employment history. You may use additional pages if needed.*

Company Name: _____ Start Date: _____ End Date: _____

Job Title / Services Provided _____

Supervisor's Name: _____ Phone: _____ Email: _____

May we contact your supervisor? ◯ Yes ◯ No

General Information

Do you have any physical limitations? ◯ Yes ◯ No *If yes, please explain:* _____

Are you required to do volunteer service hours by court order? ◯ Yes ◯ No *If yes, why?* _____

Have you ever been convicted of a crime other than a misdemeanor? ◯ Yes ◯ No

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Volunteer Experience

Have you ever volunteered in the past? ◯ Yes ◯ No *If yes, please fill in the information below. You may use additional pages if needed.*

Company Name: _____ Start Date: _____ End Date: _____

Job Title / Services Provided _____

Supervisor's Name: _____ Phone: _____ Email: _____

Language Skills: On a scale of 1-5, with 1 being the lowest and 5 being the highest, please rate your skill level for the categories below.

English: *Speak:* ◯ Yes Level: ____ ◯ No *Read:* ◯ Yes Level: ____ ◯ No *Write:* ◯ Yes Level: ____ ◯ No

Spanish: *Speak:* ◯ Yes Level: ____ ◯ No *Read:* ◯ Yes Level: ____ ◯ No *Write:* ◯ Yes Level: ____ ◯ No

Other: *Speak:* ◯ Yes Level: ____ ◯ No *Read:* ◯ Yes Level: ____ ◯ No *Write:* ◯ Yes Level: ____ ◯ No

List: _____

Volunteer Availability *(Clinic Operating Hours: 8am-5pm Monday-Friday, 8am-12pm 3rd Saturday of each month)*

I would like to volunteer in: ☐ *Medical* ☐ *Dental* ☐ *Pharmacy*

I am available to volunteer: ☐ *Monthly* ☐ *Weekly* ☐ *Yearly* ☐ *Other:* _____

The most convenient day(s) for me to volunteer is/are: ☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday* ☐ *Saturday* *(3rd Sat./mo.)*

The most convenient time for me to volunteer is: ☐ *8 am - 5 pm* ☐ *8 am - 12 pm* ☐ *12:30 pm - 5 pm* ☐ *Other:* _____

How did you hear about San José Clinic?

☐ *Clinic volunteer:* _____ *(name)* ☐ *Church:* _____ *(name)* ☐ *Clinic website* ☐ *Other:* _____ *(explain)*

☐ *Clinic employee:* _____ *(name)* ☐ *Friend:* _____ *(name)* ☐ *Advertisement* ☐ *Fair / Outreach Event*

Professional References

List 2 references that can verify your work related experience, for example one non-family member who has known you for a minimum of one year, ***and*** *one supervisor (past or present)*

Reference Name: _____ Relationship: _____

Daytime Phone: _____ Email Address: _____ *(required)*

Reference Name: _____ Relationship: _____

Daytime Phone: _____ Email Address: _____ *(required)*

Why are you interested in volunteering at San José Clinic?

Educational Requirements

Is volunteering required as a prerequisite for education requirements? ◯ Yes ◯ No *If yes, please fill in the information below, and attach course objectives.*

School: _____ Program: _____

Time Frame to Complete: _____ Hours Required: _____ Currently Enrolled? ◯ Yes ◯ No

Patient Care Application Checklist/Credentialing

*Please submit **all applicable** documentation. All applicable items on the checklist must be submitted for your application to be processed. Please note: the required credentialing process may take up to 60 days to complete.*

- ☐ *Volunteer Application*
- ☐ *CV or Resume*
- ☐ *Copy of government issued photo ID**
- ☐ *Current Licensure*
- ☐ *DEA*
- ☐ *NPI Number*
- ☐ *Immunization records (must include Hepatitis B)**
- ☐ *BLS/Healthcare CPR training (required) or ACLS*
- ☐ *Evidence of Hospital Privileges (if applicable)*
- ☐ *Malpractice Insurance***

** Originals required at orientation.*

***Patient care volunteers who do not have medical malpractice insurance, a policy is available through the Federal Tort Claims Act (FTCA) per the Clinic's request. Note: Once FTCA coverage is requested, please allow six weeks for this insurance to be effective.*

If you do not have medical malpractice insurance, do you request the Clinic apply for FTCA coverage for you? ◯ Yes ◯ No

Once your application has been approved by the department of interest, you will receive information regarding:

Statement of Health Fitness | *Statement of Malpractice History* | *Background Check* | *Clinic Orientation*

*Privileging Request Form*** | *Prescription Procedures*** | *Patient Scheduling*** | *** if appropraite*

Your role at San José Clinic is intended as a volunteer position and not intended as employment or a contractual relationship. This means you agree to perform all duties on a voluntary basis and you will not receive remuneration or payment for your service.

Consent

All information submitted in this application is true to the best of my knowledge. I release from liability San José Clinic for its acts performed in connection with obtaining and evaluating my application, credentials, qualifications and background check. I further confirm that I have the ability to perform the requested privileges. By typing my name in the space labeled "signature" below (which shall constitute my signature) and submitting this document to San José Clinic, I confirm the above representations and the information I have provided is accurate and that I have the authority to sign this form.

Signature: _____ Date: _____

If I am submitting this form electronically: By typing my name in the spaces labeled "signature" above (which shall constitute my signature) and submitting this document to San José Clinic, I confirm the above representations and the information I have provided is accurate and that I have the authority to sign this form.

Please send your completed application to San José Clinic's Volunteer Department via mail, fax, or email.

Mail: San José Clinic attn: Volunteer Dept.
PO Box 2808, Houston, TX 77252-2808

Fax: (713) 228-9414
Email: volunteerapp@sanjoseclinic.org

For questions or additional information, contact the San José Clinic Volunteer Department at (713) 228-9413 or volunteer@sanjoseclinic.org Thank you for supporting the mission of San José Clinic - to provide quality healthcare and education to those with limited access to such services in an environment which respects the dignity of each person.