



# VOLUNTEER APPLICATION

*(Please complete all parts of this application fully and accurately.)*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City / State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best Phone: \_\_\_\_\_ email: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

## Emergency Contact Information:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_ City /State: \_\_\_\_\_

## Skills & Interests

Why do you want to volunteer at the Community Dental Clinic?

\_\_\_\_\_

Hours/Days preferred: \_\_\_\_\_

Current Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Previous Occupation(s): \_\_\_\_\_

Education/Training: \_\_\_\_\_

Skills: \_\_\_\_\_

Previous Volunteer Experience (please list organizations): \_\_\_\_\_

\_\_\_\_\_

## Background Verification

Have you ever been convicted on a crime?  No  Yes – Please Explain: \_\_\_\_\_

Please list two **non-family** references who we may contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_



# VOLUNTEER APPLICANT AGREEMENT

## CONFIDENTIALITY AGREEMENT

As a volunteer of the Community Dental Clinic you may encounter information that is confidential and/or intended for the clinic or patient use only. You are required by the Community Dental Clinic and by law to maintain such information in strict confidence, to respect the confidentiality of our patients, and to disclose sensitive information only with patient consent. Should an occasion arise in which you are unsure of your obligations under this policy, it is your responsibility to consult with the Community Dental Clinic Executive Director or Clinical Coordinator. Failure to comply with this policy could result in disciplinary action, up to and including legal action.

\_\_\_ I understand that as a volunteer with the Community Dental Clinic, I may have access to patient records or information that is confidential and governed by the HIPAA (Health Insurance Portability and Accountability Act of 1996) that provides data privacy and security provisions for safeguarding medical information. I will keep these records and information confidential according to state and federal laws as well as Community Dental Clinic ethical practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT, RELEASE and WAIVER OF LIABILITY

\_\_\_ I authorize the Community Dental Clinic to obtain reference/background checks as needed and to release all such parties from all liability for any damage that may result from furnishing such information for you.

\_\_\_ I understand that to volunteer, I must abide by the established rules and codes of conduct established by the Community Dental Clinic staff.

\_\_\_ The Community Dental Clinic reserves the right to dismiss me as a volunteer due to my conduct, including but not limited to verbal and physical aggression against staff or other participants, failure to follow safety practices, and any other disruptive behavior.

\_\_\_ I understand and agree to assume any and all risks of personal injury and/or property damage to myself in any way associated with my volunteer activities and voluntarily release, discharge, waive and relinquish any and all claims or actions for damages for personal injury, death, or property damage which I may have, or which I may hereafter accrue as a result of my participation in such activities and while I am on the property of the Community Dental Clinic for any reason. This release is intended to discharge the Community Dental Clinic, in advance, from any and all liability arising out of or connected in any way with my volunteering even though that liability may arise out of negligence or carelessness on the part of the Community Dental Clinic.

\_\_\_ I further agree to indemnify and hold harmless the Community Dental Clinic for any loss, liability, damage or expense which may incur as result of any injury that I might sustain or any claim that I might bring as a result of participating in my volunteer activities and covenant not to sue the Community Dental Clinic or any its affiliates, directors, officers or staff.

I (print name) \_\_\_\_\_ acknowledge that I have carefully read this document and fully understand that this is a waiver and release of liability. I have received a copy of this document and I certify that I am at least 18 years old. I have read the above thoroughly before signing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_