99 Baskervill Drive, Pawleys Island, SC 29585 (P) 843-237-2672 (F) 843-237-0369

1101 Highmarket Street, Georgetown, SC 29440 (P) 843-520-8922 (F) 843-436-1046

 www.smithfreeclinic.org

**Volunteer Application**

**(PLEASE PRINT)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, ST, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you previously been employed or volunteered at Smith Medical Clinic, and if so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When are you available? Please highlight all that apply:**

**Monday: Tuesday: Wednesday: Thursday: Friday:**

Morning Morning Morning Morning Morning

Afternoon Afternoon Afternoon Afternoon Afternoon

Evening Evening Evening Evening Evening

**Are you a permanent or part-time resident?**

**If part-time, months available: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How often would you like to volunteer?**

**Weekly\_\_\_ Bi-Weekly\_\_\_ Monthly\_\_\_ Other\_\_\_**

**At which location would you prefer to volunteer?**

**Pawleys Island\_\_\_ Georgetown\_\_\_ Either\_\_\_**

**We need Volunteers who have Medical AND Non-Medical backgrounds to help at Smith Medical Clinic!**

**Volunteers with a *Medical Background*:**

 **Are you a Doctor, Nurse, Mental Health Counselor or Pharmacist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Do you have a current license to practice in SC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*If you are a Doctor, Mental Health Counselor, or Pharmacist, and you do not have a current license to practice in SC, you will need to apply for and receive a SC Volunteer License before you can begin to volunteer at SMC. We will be more than happy to assist you with this process.**

**Opportunities for Volunteers with *Non-Medical Background*:**

**Please check all that are areas of interest to you:**

**\_\_\_Patient Assistance Programs \_\_\_Grant Writing**

**\_\_\_Patient Education \_\_\_Newsletter Production**

**\_\_\_Fundraising \_\_\_Database Management**

**\_\_\_Interpreter \_\_\_Patient Scheduling**

**\_\_\_Reception \_\_\_Scribe**

**\_\_\_Electronic Health Record Management \_\_\_Eye Clinic Assistant**

 **(Must have knowledge of Medical Terminology)**

**\_\_\_Board Member \_\_\_Other, please describe:**

**In a few sentences, please tell us about yourself! Attaching a resume or CV is greatly appreciated. Otherwise, please summarize your skills and qualifications, and include previous or current employment or volunteer history:**

**How did you hear about Smith Medical Clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list contact information for two personal references that are not relatives:**

**1. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone and Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone and Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Background Check Permission**

**To protect our patients, Smith Medical Clinic performs background checks on all staff and volunteers. Findings on a background check may not automatically serve as disbarment from volunteering. Each finding must be analyzed by the Executive Director and Board of Directors. Some findings will require disbarment from volunteering.**

**I hereby authorize Smith Medical Clinic to perform a check on my background history.**

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

**Have you ever been convicted of a crime, excluding misdemeanor and/or minor offences, which have not been annulled, expunged or sealed by the court?**

**\_\_\_ Yes, please explain:**

**\_\_\_No**

**Have you ever been substantiated for child or elder abuse or neglect by any agency?**

**\_\_\_ Yes, please explain:**

**\_\_\_No**

**I *do not* authorize Smith Medical Clinic to perform a check on my background history. I understand that I will not be eligible to volunteer at Smith Medical Clinic.**

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

**Agreement and Signature**

**By submitting this application, I affirm the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.**

**Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**It is the policy of Smith Medical Clinic to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age or disability.**

**Thank you for completing this application form, and your interest in volunteering with us. Once we have completed processing your paperwork, we will contact you to discuss options for your volunteer opportunities!**

**Code of Conduct and Confidentiality Agreement**

**The primary mission of the volunteers at Smith Medical Clinic is to understand and serve the health and wellness needs of the medically underserved population living in Georgetown County. As a volunteer, I understand that all of the information I am exposed to regarding patients, program participants, volunteers, family members of patients/volunteers, customers, and/or employees of Smith Medical Clinic may be governed or protected by federal, state and/or local regulations and, where privileged, is to be held in the strictest confidence.**

* **No privileged information will be discussed with family, friends or any other unauthorized person.**
* **Unauthorized disclosure is cause for termination of volunteer services as well as possible civil and/or criminal sanctions.**
* **I will conduct myself with dignity, courtesy and consideration of others, and endeavor to be professional.**
* **I agree to wear my name-badge, review the schedule and alert Operations Director of any scheduling conflicts.**

**I understand that Smith Medical Clinic reserves the right to end my volunteer status as a result of:**

* **Failure to comply with SMC policies.**
* **Excessive absences without prior notification.**
* **Unsatisfactory behavior or attitude not in the spirit of SMC.**
* **Any other circumstance that would make my continued service contrary to the best interest of SMC.**

**I acknowledge that I have received and understand the SMC Volunteer Handbook.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**