



Volunteer/Intern Application

Date: _____

Name: _____ DOB: _____

Address: _____

Telephone: (H) _____ (W) _____ (C) _____

Email address: _____

Congregation where you worship: _____

How did you hear about AMM: _____

Occupation/Company: _____

Fluency in a foreign language(s): _____

Volunteer Interests: *(Check all that apply)*

- | | | | |
|--|-------------------------------------|------------------------------------|--|
| <input type="radio"/> Clinical Support | <input type="radio"/> Data Entry | <input type="radio"/> Interpreter | <input type="radio"/> Administrative Support |
| <input type="radio"/> Community Garden | <input type="radio"/> Care Partners | <input type="radio"/> Health Fairs | <input type="radio"/> Marketing/PR |
| <input type="radio"/> Other: _____ | | | |

Clinical Experience/Training: _____

Professional License # _____ (Attach front/back copy, if applicable)

- Copy of Malpractice Coverage Copy of DEA Certificate Copy of Privilege License

Please indicate your preferred days and times to work:

- Monday Tuesday Wednesday Thursday Friday Saturday Clinic (9am–12pm)
 Weekly Monthly Mornings (between 9am-12n) Afternoons (1-4:30pm)

Please list any pertinent work or volunteer history: _____

Volunteer Applicant Certification of Information:

My signature below indicates that I have provided true and complete information on this application. I further understand that false, omitted, or misleading information may result in the rejection/termination of my volunteer work with Alliance Medical Ministry. I also understand that any professional licensure or registration will be verified if required for the volunteer work performed on behalf of the ministry.

Volunteer signature: _____ Date: _____

Confidentiality Policy:

As an unpaid volunteer, my signature below signifies my understanding that all patient information is treated with utmost confidentiality out of respect for the patient and for legal and ethical reasons. My signature further signifies my understanding that, many of the communications between Alliance Medical Ministry (AMM) and its patients are protected by law as privileged or otherwise confidential, and information is highly confidential for this reason. Thus, as a condition of service as a volunteer for AMM, you are required not to 1.) Misappropriate 2.) Disclose to any third party, either directly or indirectly or aid anyone else in disclosing to any third party, either directly or indirectly, all or any part of any AMM confidential information. All volunteers are required to maintain strict confidentiality at all times concerning any confidential information to which they may be privy. Accordingly, it shall be the right of AMM to discipline or terminate any volunteer who breeches such confidentiality. My signature below signifies that I will abide by the conditions of this confidentiality policy.

Volunteer/Intern signature: _____ Date: _____

_____ Copies of Any Significant Licensure attached (if applicable)

Please (e) mail/fax to:

Alliance medical Ministry
ATTN: Regina Heroux, RN, MS, OCN Program Director
101 Donald Ross drive
Raleigh, NC 27610

Email: Rheroux@alliancemedicalministry.org

Fax: (919) 250-3322