

Welcome to the Taylors Free Medical Clinic.

It is our intention that your experience with Taylors Free Medical Clinic be one of gratification and enjoyment.

Please complete the attached application along with other pertinent documents. In addition to health information provided here, you will need to meet other requirements mandated by the State of South Carolina Health Department. These will be discussed with you during your initial orientation.

After completing the attached materials, please provide us with a copy of your driver's license or a picture ID. We can make a copy here at our clinic for your convenience.

Here are a few items of importance for your consideration:

- Always remember the confidentiality of our patients is of the utmost importance.
- Always wear your name badge (provided).
- Always look at our schedule and alert us to any time off you may need during any given month.
- Always remember we are a faith-based clinic working in a culture of caring for the whole person in the name of Jesus Christ.

We appreciate the time you are giving to our clinic and to your community. We truly realize you don't have to be here; we **want you** to be here.

Thank you so much for your support.

Connie Ashford
Volunteer Coordinator

Taylors Free Medical Clinic

HEALTH INFORMATION

Health Policy for Medical, Dental, Nursing, Specialized Professionals Personnel, and Lay Volunteer:

Applicants are qualified to volunteer if their physical and mental health is such that it will not impair their ability to render quality patient care. When the Medical Director has a reason to question the physical and/or mental health status of the volunteer, the volunteer shall be asked to submit to an evaluation of their physician and/or mental health status. Such evaluations will be prerequisite to further consideration of their application for appointment or reappointment.

If a volunteer health status changes so they are unable to perform their duties, they may be considered for a more appropriate duty.

Condition of Appointment

All volunteers, health professional and lay volunteers must fulfill the following:

- Read and sign the Attestation of Health Form.
- A tuberculin skin test is required yearly. A volunteer with a positive TB test will be referred to his/her private physician for a chest x-ray and follow-up. In the event that a volunteer is found to have a positive TM skin test, prior to beginning clinical duties, the volunteer will need to provide a note from his/her private physician.

Taylor's Free Medical Clinic

ATTESTATION OF HEALTH

REQUIRED INFORMATION:

Known medication allergies or adverse reactions:

Medication Allergy Type of Reaction You've Had

Your Physicians Name: Telephone Number:

***In case of emergency, please contact:**

Name: _____ Telephone: _____

Relationship: _____

OPTIONAL INFORMATION:

List any medical condition of which you would like us to be aware of, even though these conditions do not impair your capacity to perform as a lay volunteer. Please list medications that you are currently taking. This information is needed so that we may be aware of your needs should you require health assistance on an urgent or emergency basis while volunteering as the Clinic. Information will be treated with strict confidentiality.

Medical Conditions:

I, _____, attest and can document if called upon, that I currently am free of any physical or mental ailments that would impair my ability to perform the duties of a Volunteer. I am free of addiction to drugs, alcohol, or any other recreational chemical substances. I understand that I may not hold Taylors Free Medical Clinic responsible for ailments that I have disclosed or have not disclosed.

Signature: _____ Date: _____
Taylors Free Medical Clinic

VOLUNTEER AGREEMENT

- I shall hold as absolutely Confidential all information that I may obtain directly concerning patients, doctors or personnel, and not seek to obtain Confidential information from patients.
- I shall submit to any immunizations (TB) that may be necessary as part of my volunteer service.
- I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my work professional in quality.
- I shall attempt to resolve any of my volunteer problems with the volunteer in charge of my department. If unsuccessful, I will attempt to resolve any such problems with the Volunteer Coordinator or the Executive Director.
- I shall make my best effort to fulfill my commitment to the clinic by completing all assignments that I accept.
- I shall at all times uphold the philosophy and standards of the Clinic to serve every person, without regard for race, gender or religion, in the name of Jesus Christ.
- I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of:
 - Failure to comply with Clinic policies, rules, and regulations.
 - Absences without prior notification.
 - Unsatisfactory attitude, work or appearance.
 - Any other circumstances, which in the judgment of the department volunteer in charge, would make my continued services as a volunteer contrary to the best interest of the Clinic.

I have read each of the above conditions and agree to be bound by them.

Signature: _____ Date: _____

Print Name: _____

Taylor's Free Medical Clinic

CONSENT FOR HEALTH SERVICES

NAME: _____

**CONSENT TO RECEIVE MEDICAL SERVICES PROVIDED BY A PHYSICIAN,
DENTIST, NURSE OR OTHER HEALTH CARE PROVIDER VOLUNTARILY AND
WITHOUT EXPECTATION OF COMPENSATION.**

I CONSENT TO RECEIVE MEDICAL SERVICES AND TREATMENT RENDERED BY ONE WHO HAS VOLUNTARILY AGREED TO PROVIDE SUCH TREATMENT WITHOUT COMPENSATION OR EXPECTATION OR PROMISE OF COMPENSATION AS PROVIDED UNDER SECTION 33-55-210 OF THE CODE OF LAWS OF SOUTH CAROLINA.

Signature Date

Taylor's Free Medical Clinic
ADMINISTRATION/SUPPORT VOLUNTEER APPLICATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____

Int. _____

STREET ADDRESS: _____ CITY: _____ STATE _____

ZIP: _____

TELEPHONE: _____ ALTERNATE PHONE

#: _____

E-Mail: _____ FAX: _____

Emergency Contact: _____

Contact's Phone: (Home) _____ Phone: (Work) _____

Date of Birth: _____ Social Security Number: _____

Other languages spoken: _____

Occupation: _____ Years of Experience: _____

Describe any special office skills or experience that you would like us to know about:

Volunteer Activity Desired Please check all applicable boxes

I would like to do: I can work: Preferences

Clerical Work _____ As needed _____

Computer Work _____ 1 day/week _____

Committee Work _____ 1 day/month _____

Facilities _____ 2 days/quarter _____

Medical Eligibility _____ 1 day/quarter _____

Medical Records _____ 2 days/quarter _____

Pastoral _____ days per _____

Reception/Telephone/Greeter _____

Translator _____ Other comments: _____

Special Projects _____

General Help _____

Other _____

Are you computer literate? Yes____ No____ Beginner____ Intermediate____ Proficient

Would you like to learn to use the computer? Yes____ No____

What months are you not available? _____

Comments or suggestions or other information which we can use to better serve you as you serve others at Taylors Free Medical Clinic

Confidentiality Statement: I understand that in my capacity as a volunteer with the Taylors Free Medical Clinic I may come into contact with confidential information. I agree to protect this information to the best of my ability and not to divulge it during my volunteer service or after my volunteer service has ended.

Signed: _____ Date: _____

Taylors Free Medical Clinic

MEDICAL/DENTAL/PHARMACY/NURSE VOLUNTEER APPLICATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____

Int.____

STREET ADDRESS: _____ CITY: _____ STATE _____

ZIP: _____

TELEPHONE: _____ ALTERNATE PHONE
#: _____

E-Mail: _____ FAX:

Emergency Contact: _____

Contact's Phone: (Home) _____ Phone: (Work) _____

Check One: __MD __DMD __APRN __RN __LPN __ Pharmacist __Pharmacy Tech __Other

License Number: _____ Expiration date: _____ Date of Birth: _____

Social Security Number: _____ Other languages spoken _____

Describe any special skills or experience that you would like us to know about:

Please check all applicable boxes

I can work: Preferences

As needed _____
1 day/week _____
1 day/month _____
2 days/quarter _____
1 day/quarter _____
2 days/quarter _____
___ days per _____

Other comments: _____

What months are you not available? _____

Comments or suggestions or other information which we can use to better serve you as you serve others at Taylors Free Medical Clinic _____

Confidentiality Statement: I understand that in my capacity as a volunteer with the Taylors Free Medical Clinic I may come into contact with confidential information. I agree to protect this information to the best of my ability and not to divulge it during my volunteer service or after my volunteer service has ended.

Signed: _____ Date: _____