Dear Doctor:

Thank you for your interest in volunteering with the Taylors Free Medical Clinic. We want your experience to be one of gratification and enjoyment.

Taylors Free Medical Clinic is a faith-based effort, looking at the whole person: body, mind and spirit. We offer counseling, referrals to other agencies, and health and wellness classes. Taylors Free Medical Clinic has also been able to serve the growing Hispanic community and their health needs.

We are offering a clinic on Thursday nights for the uninsured, underinsured and medically indigent people in the greater Taylors area, and have recently started Tuesday night surgery, dermatology, gynecology and orthopedic clinics. We have a pharmacy that is dispensing several thousand dollars worth of medications weekly.

For credentialing purposes, please complete the enclosed application packet, provide us with the following documentation and return it to the address below.

*A copy of your resume
*A copy of your medical license
*A copy of your driver's license or picture ID
*A copy of your malpractice insurance cover sheet (The clinic is approved for the Federal Tort Claims Act for malpractice insurance on our physicians.)
*Two (2) references, with addresses and phone numbers
*A copy of your TB test
*Your Social Security number
*Your Date of Birth

We look forward to working with you. Please call me at 864-244-1134 to schedule your time at the clinic.

Sincerely,

Karen A. Salerno
Executive Director

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.

Taylors 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.

Taylors 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 EXPECTAION OR PROMISE OF COMPENSATION AS PROVIDED UNDER SECTION 33-55-210 OF THE CODE OF LAWS OF SOUTH CAROLINA.

_____ _____
Signature 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: _____