

## Volunteer Application

### Contact Information

**Name**

**Street Address**

**City, ST ZIP Code**

**How long at this address?**

**Home Phone**

**Mobile Phone**

**E-Mail Address**

**Date of Birth**

### Person to Notify in Case of Emergency

**Name**

**Street Address**

**City ST ZIP Code**

**Home Phone**

**Cell Phone**

### Availability

When are you available?	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

### Interests

**Tell us which areas interest you!**

Patient Care

Grant Writing

Patient Assistance Programs

Newsletter Production

Patient Education

Patient Scheduling

Fundraising

Database Management

Reception

Benefit Bank Counselor (must be certified)

Electronic Health Record Management (must have knowledge of medical terminology)

Scribe

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

**If so, which profession, and do you have a current license in SC?**

### Special Skills or Qualifications

**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:**

**At which location would you prefer to volunteer? Pawleys Island Georgetown Either**

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

### Background Check Permission

**To protect patients, Smith Medical Clinic performs background checks on 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

**How many years has this been your legal last name? \_\_\_\_\_**

**Social Security No: \_\_\_\_\_**

**How long have you lived in South Carolina?  Less than 7 years  Greater than 7 years**

**If less than 7 years, please include additional address(es) and length of stay at each to complete 7 year history:**

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

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

Please answer the following

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

<input type="checkbox"/> <b>Yes</b>	<b>If yes, please explain:</b>
<input type="checkbox"/> <b>No</b>	

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

<input type="checkbox"/> <b>Yes</b>	<b>If yes, please explain:</b>
<input type="checkbox"/> <b>No</b>	

### Agreement and Signature

**By submitting this application, I affirm that 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, Inc. 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 for your interest in volunteering with us.**

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

**Name** \_\_\_\_\_

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

**Phone** \_\_\_\_\_

**Email** \_\_\_\_\_

**Name** \_\_\_\_\_

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

**Phone** \_\_\_\_\_

**Email** \_\_\_\_\_

## **CODE OF CONDUCT & 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 ID badge, review the schedule and alert the office manager 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.

Signed: \_\_\_\_\_

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

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

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