Medical Missions for Christ Clinic

Volunteer Application Packet

Dear Prospective Volunteer:

Thank you for your interest in volunteering with Medical Missions for Christ Clinic. Our mission is: *"To provide quality health care in a manner that reflects the love of Christ."* We could not do this important work without the help of our volunteers. We'd love to have you be part of our ministry.

All applicants are required to:

1. **Return the completed application packet.**

2. **Provide two references.** References must be from non-relatives who have known you for at least two years. Professional references are preferred. You may return these with your application or each may be mailed to us by the person giving the reference. If you have any problems providing references, please give me a call to discuss.

3. Attach a copy of a current **driver's license or government issued photo ID.**

4. If you are a licensed health professional, attach a copy of your **current license(s) and/or certificate(s)**.

If you have any questions or need more information about our volunteer program, please call our office at 573-346-7777.

Thank you again for your interest in our ministry and I hope to soon be working with you!

Grace to you and peace,

Executive Director

Notice to Prospective Employee or Volunteer

Our Statement of Faith
Thank you for your interest in working or volunteering for **Medical Missions for Christ Clinic**. We have adopted a policy that opens the Mission to employees and volunteers who are like-minded spiritually, and who are supportive of our philosophy. Our purpose is to provide quality health services to qualified individuals of the lake area in a manner that reflects the love of Christ. Before applying to become an employee or volunteer for our clinic, we ask that you read the following Statement of Faith and sign, affirming your commitment to abide by these:

- ***We believe the Bible to be the inspired, the only infallible, authoritative Word of God. (1 Thess.2:13, 2 Timothy 3:16)***
- ***We believe there is one God, eternally existent in three persons: Father, Son, and Holy Spirit. (Matt.28:19, John 10:30, Eph. 4:4-6)***
- ***We believe that human life is sacred from conception to its natural end; and that we must have concern for the physical and spiritual needs of our fellow men. (Ps 139:13, Isaiah 49:1, Matt. 22:37-39)***
- ***We believe that God wonderfully and immutably creates each person as male or female. These two distinct, complementary genders together reflect the image and nature of God. (Gen 1:26-27.) We believe that any form of immorality is sinful and offensive to God. (Matt 15:18-20, 1 Cor 6:9-10)***
- ***We believe that in order to preserve the function and integrity of Medical Missions for Christ Clinic to provide a biblical role model to the patients and the community, it is imperative that all persons who serve as volunteers, agree to and abide by this Statement.***

Please consider this Statement of Faith carefully. If your behavior is not compliant with the beliefs and lifestyle choices reflected in the Statement of Faith, it will be best for all concerned if you do not apply to work for the clinic.

Biblical principles are integrated into our philosophy. Our staff is committed to apply the truths of God's Word to every aspect of life. If you are in agreement with the bulleted points above, we look forward to considering your application for our organization.

I affirm that:

1. I understand that Medical Missions for Christ does not allow employees or volunteers to conduct themselves in any manner that contradicts the bolded and italicized statements above.
2. I commit my behavior to be complaint with the beliefs and lifestyle choices reflected in the Statement of Faith while working at Medical Missions for Christ Clinic.

______________________________	______________________________	_____________
Signature	Print Name	Date

MEDICAL MISSIONS FOR CHRIST CLINIC

Volunteer Application

Date of Application:___________________

PERSONAL INFORMATION

|________________________|_____|______________________________________|______|______|______|

First Name M.I. Last Name Date of Birth mm/dd/yyyy

All previous names you have used (including maiden):____

____

|____________________________________|_____________________________|______|_______________|

Street Address City State Zip

|____| |___________| - |________ |- |_____________|

eMail Address Social Security Number

|___________________________|____________________________|_________________________________

Home # Cell # Work #

Emergency Contact Name & #____

Have you been convicted or pleaded no contest to, a felony? Yes□ No□ If yes, please explain (continue on back, if needed): _______
____Would you consent to a criminal history check? Yes□ No□

AVAILABILITY

How often would you be available to work?____

Date you are available to start volunteering: ____

Comments regarding your schedule or availability: ____

VOLUNTEER EXPERIENCE

Company/Agency	Location	Description of Duties
Dates	Reason for Leaving	
Company/Agency	Location	Description of Duties
Dates	Reason for Leaving	
Company/Agency	Location	Description of Duties
Dates	Reason for Leaving	

RELATED WORK EXPERIENCE

Company/Agency	Location	Description of Duties
Dates	Reason for Leaving	
Company/Agency	Location	Description of Duties
Dates	Reason for Leaving	
Company/Agency	Location	Description of Duties
Dates	Reason for Leaving	

For Office Use Only **References Received** ☐1 ☐2 **Reviewed by:**_____________________________ **Date:** ____________

Interviewed by: 1)_________________________________ **Date:** ___________ **Copies to**: ☐ Exec. Director ☐_________

2)_________________________________ **Date:** ___________ **Original to**: ☐ Office Manager

EDUCATION

School Name	City, State	Degree/Diploma	Graduation Date

AREAS OF MEDICAL INTEREST (Check all that apply.)

_____ Licensed Physician*+
_____ Physician's Assistant
_____ Certified Dental Assistant or Hygienist (circle one)
_____ Licensed Dentist*+
_____ Diabetic Educator
_____ Nursing Staff - RN, LPN, CMA, CMT (circle one)*
_____ Nurse Practitioner*+
_____ Other ____

_____ Chiropractor*
_____ Physical Therapist
_____ Patient Care Assistant
_____ Pharmacy Tech
_____ Behavioral Health* (circle one) LSCW, LPC, Psychiatrist, Psychologist, Psychiatric Nurse

*License #____________________ +DEA #________________

Other Skills

Our ministry uses volunteers in a wide range of capacities. Please describe any skills or experience you have as these may be helpful to our clinic. For example: accounting, data entry, computers, social media, phone skills, grant writing, public speaking, fundraising, medical records, scheduling, etc: ____

Are you bilingual?______________ If yes, what language(s)?______________________________

Please list any other skills, licenses, certifications, training, awards, etc.______________________

Church you attend and location:____

Church activities:____

Please explain briefly why you would like to volunteer:____

Anything else you would like us to know about you:____

I certify that all statements given here are true and complete. I authorize the investigation of all statements and references as noted on this application.

Signature____ Date____________________

Please drop off your completed application at 1974 N. Bus. Rte 5 or mail to:
Medical Missions for Christ Clinic
PO Box 1948, Camdenton, MO 65020

MEDICAL MISSIONS FOR CHRIST CLINIC

Volunteer Professional Reference Form

Volunteer Applicant's Name:____

The person listed above has applied to be a volunteer at Medical Missions for Christ Clinic and wishes to use you as a reference. Your response is confidential. Please answer all questions on this form and either return to the potential volunteer in a sealed envelope with your signature across the seal or mail directly to us at MM4C Volunteer, PO Box 1948, Camdenton, MO 65020. Your quick response is greatly appreciated.

Your Name:________________________ Title:________________________

Organization or Business:____

Address:____

City:________________________ State:______________ Zip:______________

Phone:______________ Fax:______________ Email:____________________

Questions:

How long have you known this individual?______________________________

What is your relationship to this individual?______________________________

How did/does this individual interact with co-workers, associates and/or others?______________

____

How well does this individual respond when more than one priority competes for his/her time?__________

____

Would you recommend this individual for a volunteer position with our organization?______________

Briefly describe any areas of concern (this will be treated as confidential):______________

____

Are you willing to speak to us by phone if we have other questions about the applicant? Yes □ No □

Question	**Unsatisfactory**	**Satisfactory**	**Excellent**
Please rank this individual's quality of work			
Please rank this individual's dependability			
Please rank this individual's involvement with clients/patients/customers/others			
Please rank this individual's leadership capabilities			

Additional comments are welcome on the back.

Reference's Signature:________________________________ Date:______________

Volunteer Professional Reference Form

Volunteer Applicant's Name:____

The person listed above has applied to be a volunteer at Medical Missions for Christ Clinic and wishes to use you as a reference. Your response is confidential. Please answer all questions on this form and either return to the potential volunteer in a <u>sealed</u> envelope with your signature across the seal or mail directly to us at MM4C Volunteer, PO Box 1948, Camdenton, MO 65020. Your quick response is greatly appreciated.

Your Name:______________________________ Title:__________________________

Organization or Business:____

Address:____

City:___________________________ State:______________ Zip:______________

Phone:________________ Fax:________________ Email:______________________

Questions:

How long have you known this individual?_________________________________

What is your relationship to this individual?_______________________________

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Please rank this individual's involvement with clients/patients/customers/others			
Please rank this individual's leadership capabilities			

Additional comments are welcome on the back.

Reference's Signature:______________________________________ Date:______________

RELEASE OF INFORMATION

I authorize Medical Missions for Christ Clinic and its authorized representative(s) to consult with any third party who may have information bearing on my credentials, clinical competence, character, ethics, behavior, or any other matter related to my qualifications.

This authorization includes the right to inspect or obtain any and all documents, recommendations, reports, statements, or disclosures relating to such questions.

I agree not to sue the clinic, the Board of Directors, staff, or volunteers that act in good faith by and/or for the clinic and its Board of Directors, staff, or volunteers for any matter relating to the evaluation of my qualifications for application as a volunteer.

____ ________________
Signature Date

____
Printed Name

_________________________ _________________________
Date of Birth Medical License Number & State

MM4C's HIPAA Privacy Policy

Definitions

Health Insurance Portability and Accountability Act (HIPAA**)** is Public Law 104-19, enacted on 8-21-96, that establishes standards for electronic exchange, privacy and security of health information. Further privacy regulations, known as the HIPAA Privacy Rule, were issued by the Secretary of Health and Human Services (HHS) in 2000 and have continued to be updated since.

Covered Entity is defined in the HIPAA rules as a health plan, a health care clearinghouse, or health care provider who electronically transmits any health information.

HIPAA Compliance Officer is the person assigned by a covered entity to oversee training and HIPAA compliance.

Protected Health Information (PHI) is individually identifiable health information that is transmitted or maintained in any form, and/or is transferred by electronic media.

About HIPAA Compliance

Medical Missions for Christ Clinic (MM4C) is a Covered Entity. HIPAA rules apply to us.

The organization that oversees HIPAA privacy compliance is the Office for Civil Rights.
MM4C's current HIPAA Compliance Officer is the Executive Director, Carolyn Bowling.
Employees, volunteers, and trainees who violate policies related to HIPAA compliance will be subject to disciplinary action. There are also *criminal penalties* if you knowingly obtain or disclose PHI in violation of HIPAA. Penalties for individuals range from $50,000 and 1 year in jail to $250,000 and 10 years in jail, depending on motive.

MM4C Policy Statement

Employees, volunteers, and trainees of Medical Missions for Christ Clinic (MM4C) have access to PHI that must be treated as confidential. It is the responsibility of each individual to assure absolute confidentiality by following HIPAA privacy rules.

Employees, volunteers, and trainees must never share the names of any patients with any person or entity outside MM4C unless (1) that person or entity could be described as directly involved in the patient's continuum of care (e.g., a specialist, testing facility, etc) or (2) as required by the HIPAA Privacy Rule as a matter of national priority (e.g., health or safety threat, law enforcement purposes, etc).

PHI may not be transmitted in any form or by any media to any entity outside MM4C (except to another Covered Entity involved in the patient's care) without the patient's written authorization.
No other personal information about a patient, including financial or lifestyle matters, can be discussed with any person or entity that is not part of MM4C or directly involved in the patient's continuum of care.

If in doubt, ask the HIPAA Compliance Officer before you share information!

Directives

1. Never discuss patients or PHI in public areas of the clinic. Remember, our walls are very thin and few areas are truly private.
2. Telephone conversations must be conducted in an area and in a manner where patient privacy can be maintained.
3. Computer monitors must be positioned to protect PHI from public view and cannot be left unattended with confidential information displayed.
4. Charts and other confidential documents must not be placed where a patient's name or PHI can be viewed by the public.
5. Confidential information must not be left on copy machines or in public areas.
6. Patients are not to be left unattended in "staff only" areas (e.g., nurses station, dispensary, front office, etc)
7. If a patient's name is on material to be discarded, it must be shredded or otherwise completely destroyed.
8. Donated drugs in containers labeled with a person's name must have the name removed before placing the container on the dispensary shelf.
9. PHI given over the phone must adhere to the same standards as other forms of media. Messages may be left on answering machines or voicemail only if authorized by the patient in writing.
10. Patient information may be shared with family or friends only if authorized in writing by the patient.
11. Employees, volunteers, and trainees are required to report breaches of privacy to the Compliance Officer or, if unavailable, a staff member in charge.

Please keep this document for future reference. If you have questions before signing the MM4C HIPAA Compliance Agreement, please contact the Compliance Officer.

HIPAA Confidentiality Agreement

I have read, and agree to abide by, Medical Missions for Christ Clinic's HIPAA Privacy Policy. I agree to seek clarification from my supervisor or the HIPAA Compliance Officer if I do not understand any aspect of the policy.

I agree to maintain the confidentiality of all information obtained, witnessed, or otherwise made available to me in the course of my employment, volunteering, or training including (but not limited to) patient name, medical condition, medical or social history, financial or other personal information. Release of any patient information to another person or entity will comply with the clinic's HIPAA Privacy Policy. If in doubt, I will seek clarification from the HIPAA Compliance Officer.

I understand I am responsible for reporting all such violations to the HIPAA Compliance Officer.

I understand that any violation of the HIPAA regulations or clinic privacy policies may subject me to disciplinary action, up to and including termination.

Signature: ____

Printed Name: ____

Date: __________________