Dear Potential Volunteer,

Thank you so much for your interest in volunteering your time and talent to serve the patients of HealthLink Dental Clinic!

Volunteers really are the backbone of our organization; our free dental clinic *simply would not exist* without the generosity of local dental professionals.

Whether you can volunteer once a week, once a month, or join our email list to be notified of open shifts for which we need help – any time commitment to our 501c3 nonprofit is greatly appreciated!

In addition to this completed application, we will also need you to provide the following so that we can comply with regulations and complete the credentialing process:

- Copies of your professional licenses and certifications
    - Include proof of CPR and Child Abuse Reporter training
- A copy of photo identification
- Verification of TB testing and results within the past year
- Verification of Hepatitis B immunization or waiver

HealthLink is enrolled in the Federal Tort Claims Act (FTCA) Medical Malpractice program. The Clinic sponsors volunteer dental professionals to be "deemed" Public Health Service (PHS) employees for the purpose of FTCA medical malpractice coverage. FTCA deemed status provides the volunteer with immunity from medical malpractice lawsuits resulting from his/her subsequent performance of dental or related functions within the scope of his/her work at the free clinic

Please do not hesitate to contact me if you have any questions or concerns. You can reach me directly at (267) 699-0120 or jsalisbury@healthlinkdental.org.

We look forward to you joining our volunteer team!

Sincerely,

Jenny

Jenny Salisbury, CFRE
Executive Director

Dental Volunteer Application

Date: ______________________

Name: ____

Home Address: ____

City: ________________________ State: ______ Zip Code: __________________

Phone #: ____

Cell #: ____

Email: ____

Social Security #: ____

Date of Birth: __________________________________

Employer (if any) & how long? ____

Employer Address: ____

Work #: ____

Fax #: ____

Local emergency contact: ____

Relationship: ____

Emergency contact phone #: ____

Foreign language(s) spoken fluently: ☐ Spanish ☐ Other: ___________________________

How were you referred to HLDC? ____

Best way to contact you: ☐ Work ☐ Home ☐ Cell ☐ Email

Dental Volunteer Application

Availability

	Monday	Tuesday	Wednesday	Thursday	Friday
Clinic Hours	8am – 4pm	8am-7pm	8am-2pm	8am-7pm	8am-12noon
	☐	☐	☐	☐	☐
Time(s) Available					

References:

Name: ____

Relationship: ____

Phone #: ____

Name: ____

Relationship: ____

Phone #: ____

I give my permission to HealthLink Dental Clinic to list me as a volunteer and to use my name and/or photographs for internal publications and on the website as well as promotional/marketing initiatives that include but are not limited to newspapers, magazines, etc.

____ _____________________

Signature Date

I authorize HealthLink Dental Clinic to conduct a criminal background check and to contact references prior to acceptance to the HealthLink volunteer staff.

____ _____________________

Signature Date

Volunteer Authorization

Name: ____

I give my consent for HealthLink to do the following as appropriate in exploring my candidacy for volunteering and for biannual re-credentialing:

1. Conduct a Pennsylvania criminal background check.
2. Query the National Practitioner DataBank (NPDB). *I understand that the privilege of querying the NPDB includes the responsibility for HealthLink to report to the NPDB.*
3. Verify the status of my professional license(s).
4. Secure Verification of Board Status from American Board of Oral & Maxillofacial Surgery.

____ _____________________

Signature Date

<u>Credentialing Information</u>:

Social Security #: ____

Date of Birth: ________________________________

Undergraduate school: ____

Professional school of study: ____

Year of graduation: ________________________________

License #: ____

Certification #: _____________________________________

Areas of certification: ____

Areas of practice: ____

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1. Best way to contact you: ☐ Phone – Cell ☐ Phone – Office ☐ Text ☐ Email
2. Where would you prefer to receive HealthLink mail? ☐ Home ☐ Office

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Confidentiality & Commitment Statement

I understand and agree that in the performance of my duties as a volunteer at HealthLink Dental Clinic, a non-profit organization, I must abide by all policies and procedures, including holding strictly confidential all medical information that I may obtain directly or indirectly concerning patients. I understand that failure to comply with these requirements may result in my dismissal as a volunteer.

I hereby give HealthLink my permission to obtain information relating to my criminal history record and to conduct background checks on me. The criminal history record, as received from the reporting agencies, may include juvenile offense, arrest and conviction data as well as plea bargains and deferred adjudications. I understand that this information shall be used, in part, to determine eligibility for a volunteer position within this organization. I also understand that as long as I remain a volunteer at HealthLink, the criminal history records check may be repeated from time to time.

I am volunteering my services to HealthLink, solely for my personal purpose or benefit without promise or expectation of compensation or monetary benefits. I agree to serve as a volunteer without salary and have received no promises of compensation.

I have volunteered my time and services because of my support for HealthLink and my desire to participate actively in the furtherance of its mission. As such, on behalf of me, my personal representatives, heirs, successors and assigns ("my Representatives"), I specifically release, discharge, indemnify and hold harmless HealthLink, and any and all of its members, directors, officers, agents, volunteers, employees, successors and assigns ("its Representatives") of and from any and all liability, claims, expenses, losses, responsibility, or damages whatsoever (including attorney's fees and costs) for any death, personal injury or property damage resulting from or arising out of my presence at HealthLink or my service as a volunteer. I further waive all claims of liability that I or my Representatives may have against HealthLink or its Representatives. On behalf of me and my Representatives, I covenant and agree to make no claim, nor to institute any suit, action or proceeding against either HealthLink or its Representatives relating to any accident, incident or occurrence arising out of, or in connection with, my volunteer activities.

Date: ________________________

Print Name: ____

Volunteer's Signature: ____

Witness: ____

Personal Statement of Health / Fitness

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 understand that I may not hold HealthLink Dental Clinic responsible for ailments that I have or have not disclosed.

____
Printed Name of Volunteer, Credentials

____ __________________
Signature of Volunteer Date

Confirmed by:

____ __________________
Bernie Dishler, DDS Date
HealthLink Board President

Or

____
Printed Name of Confirming Party

____ __________________
Signature Date

Statement of Hepatitis B Vaccination

I attest that I have received the series of three injections of Hepatitis B vaccine. The series was completed ______________________________. (Please enter date.)

____
Printed Name of Volunteer

____ ____________________
Signature of Volunteer Date

____
Signature of Executive Director

Hepatitis B Vaccine Waiver

I understand that due to my Occupational Exposure to blood or other potentially infectious materials that I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at that time at no charge to me.

Have you previously declined the hepatitis B vaccination series? ☐Yes ☐No ☐NA

Are you declining now because you have had the series before? ☐Yes ☐No ☐NA

Are you declining now because you have tested positive for immunity? ☐Yes ☐No ☐NA

____
Printed Name of Volunteer

____ ____________________
Signature of Volunteer Date

____
Signature of Executive Director

Tuberculosis Skin Test Form

Volunteer Name: ____

Testing Location: ____

Date Placed: ________________________

Site: Right Left

Lot #: ____________________ Expiration Date:_______________

Signature (administered by): __________________________________

RN MD Other:_____________________

Date Read (within 48-72 hours from date placed): _____________________

Induration (please note in mm):____________________mm

PPD (Mantoux) Test Result: ☐ Negative ☐ Positive*

*If skin test positive:

1. Refer individual for chest X-ray.
2. Report to the county of residence Health Department.

Signature (results read/reported by): ____________________________

☐ RN ☐ MD Other:________________

In order for this document to be valid/acceptable, all sections of this form must be completed.

ANNUAL TESTING IS REQUIRED FOR VOLUNTEERING

FTCA Authorization

HealthLink is enrolled in the Federal Tort Claims Act (FTCA) Medical Malpractice program. The Clinic sponsors volunteer health care professionals to be "deemed" Public Health Service (PHS) employees for the purpose of FTCA medical malpractice coverage.

FTCA deemed status provides the volunteer with immunity from medical malpractice lawsuits resulting from his/her subsequent performance of dental or related functions within the scope of his/her work at the free clinic. Claimants alleging acts of medical malpractice by a deemed volunteer health care professional must file their claims against the United States according to FTCA requirements. The payment of claims will be subject to Congressional appropriations for the program.

There is additional information available at http://bphc.hrsa.gov/freeclinicsftca/application.htm

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I give my authorization for HealthLink to sponsor me for FTCA deemed status. I understand and agree that HealthLink will review and I will provide all credentialing documentation necessary to maintain my deemed status.

Date: ____

Print Name:______________________________________

Volunteer Signature:_______________________________

Witness:____

Photo Release Form

I, ____, agree to allow HealthLink Dental Clinic to use my photographs, likeness, and image in its marketing efforts and all publications, which include but are not limited to: printed materials, newspapers, televised broadcasts, and internet postings.

My signature below provides my consent.

____
Volunteer Printed Name

____
Volunteer Signature

____
Date

____
Witness Signature

Scheduling Procedure Summary

HealthLink Dental Clinic is primarily a volunteer organization, and volunteers are the greatest assets HealthLink has with which to address patient needs. The scheduling of volunteers is therefore tremendously important; HealthLink's administration starts this process no less than 6 weeks in advance of a given month.

Request for schedules are sent to volunteers via email or preferred method of contact. Volunteers are asked to respond with their availabilities no less than 2 weeks prior to a given month, and must notify the receptionist or clinic coordinator promptly of any changes in schedules.

The volunteer monthly calendar, located in the clinic, provides a list of the days and times each volunteer is scheduled. To ensure efficient operations of the clinic, if the professional volunteer has their own schedule in the Dental database, it is vitally important that they notify the receptionist or clinic coordinator of any additions or changes immediately.

My signature below implies my understanding of this policy.

____
Volunteer Printed Name

____
Volunteer Signature

____
Date