



Volunteer Application

Please print

First Name Last Name
 Address City/State/Zip.
 Telephone Social Security #
 Date of Birth Spouse's Name
 Email Address Male/Female (circle correct response)

Physical Limitations: No Yes (Please Explain)

Work/occupation..... **Most recent employer (optional)**.....

List previous/current volunteer experience.....

Interests: (tell us which areas you are interested in volunteering)

Administration	Fundraising	Newsletter production
Events	Mentor Program	Volunteer coordination
Medical/Clinical	Website/social network	Providing meals

Skills (List your skills and indicate proficiency level) Skilled Can Teach Amateur

1.....
 2.....
 3.....

Languages Fluent Read Write

1.....
 2.....

Volunteer availability: (Circle all applicable)

Number of Days per week: 1 2 3 4 5
 Monday Tuesday Wednesday Thursday Friday No Preference

In an emergency, notify:

First Name Last Name
 Address.....
 City/State/Zip Telephone.....

CONFIDENTIALITY STATEMENT

I acknowledge that this statement applies to all members of the workforce, including but not limited to, employees, volunteers, students, physicians, resident physicians, and third parties, whether temporary or permanent, paid or not paid, visiting, or designated as associates, who are employed by, contracted to, or under the direct control of The Cooperative Christian Ministries & Clinic.

I acknowledge that CCMC has formally stated its commitment to preserving the confidentiality and security of health information, whether it is maintained or distributed in paper, electronic, video, verbal, or any other medium or format. I understand that I am required, if I have access to such health information, to maintain its confidentiality and security.

I understand that access to health information created, received, or maintained by CCMC is limited to those who have a valid business or medical need for the information or otherwise have a right to know the information. I understand that there are many administrative, physical and technical safeguards in place to protect the privacy and security of this health information, and that any attempt to bypass or override these safeguards is a violation of federal and state laws and the privacy and security policies of the Cooperative Christian Ministries & Clinic.

I understand that anyone who is authorized to access electronic health information within CCMC will be issued a unique user identification and password, and that any person who knowingly discloses their user ID or password to others, uses or discloses another individual's user ID or password, or accesses any electronic protected health information without authorization is subject to disciplinary action, up to and including dismissal. In addition, I understand that all CCMC and affiliate workforce members must comply with applicable Information Technology Security Policies.

I further understand that, with the exception of purposes related to treatment, access to, uses and disclosures of, and requests for an individual's health information must, to the extent practicable, be limited to the minimum necessary to accomplish the intended purpose of the approved use, disclosure or request.

I understand that any known or suspected violation of the confidentiality or security of health information must be reported to my immediate supervisor or to the Privacy Officer (CCMC Administrator) immediately.

Signature

Date

AUTHORIZATION TO OBTAIN CRIMINAL BACKGROUND REPORTS

I authorize CCMC to obtain criminal background reports and/or investigative criminal background reports for background investigation. I understand that these reports might include, but are not limited to, a search of my criminal background, reference checks, driving record checks, and verification of my identification and Social Security Number. I agree that this Disclosure/Authorization, in original or copy form, is valid for all current and future criminal background reports.

Signature

Date