



# The Neighborhood Christian Clinic

*Restoring Health & Restoring Lives*

**1929 W. Fillmore, Bldg. C  
Phoenix, AZ**

## **Thank you for volunteering!**

**We are glad to have you as part of our team. The following procedures are to help you have a pleasant experience while serving as a volunteer.**

❖ **Confidentiality:**

You may be privileged to know personal information about patients. Please maintain complete confidentiality concerning the patients' comments and records.

❖ **Children**

It is to safeguard the health and safety of your children that we ask you not to bring them with you to the clinic.

❖ **Dress Code:**

All clothing worn, whether uniforms or street clothes, should be clean and in good repair. If you have scrubs, please wear them. T-shirts with pictures, slogans, or advertisements are inappropriate attire and should not be worn while working. Also considered inappropriate are shorts, cutoffs, tank shirts, midriff shirts and tight or revealing clothing. Shoes should be clean and in good repair.

All employees and volunteers are to wear their nametag in a readily visible location while at work.

It is suggested that you not wear expensive jewelry, perfumes, etc.

❖ **Commitment:**

We take very seriously your commitment to the clinic and value your time and effort. Therefore, we ask that you notify us as far in advance as possible when you cannot keep your scheduled service time.

❖ **Safety:**

Please be vigilant of your surroundings as you come and leave the clinic. Be sure to have a clinic staff member/volunteer chaperone you to your car. Do not leave valuables inside your car where they are visible. Lock your car.

# Application for Licensed Professional Volunteers

## The Neighborhood Christian Clinic, Inc.

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

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Numbers: Work: \_\_\_\_\_

Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Basic Life Support Certified:  Yes  No

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

Present Professional Practice Location (s):  
(If none, last active status.)  
\_\_\_\_\_  
\_\_\_\_\_

Spanish Bilingual?  No  Yes

Do you have any physical or health limitations/conditions that could impact patient care?  
 No  Yes (Describe): \_\_\_\_\_

TB (Tuberculosis) skin testing (recommended yearly) and Tetanus/Diphtheria vaccine (recommended every 5 years) is available in the Clinic for ALL volunteers. The Hepatitis B vaccine series is highly recommended. Please notify Volunteer Coordinator if you desire this and are able to return within 72 hours to have test read by appropriate staff.

Please initial the following:

- I have had the Hepatitis B vaccine series.
- I have NOT had the Hepatitis B vaccine series and DO NOT wish to receive it.
- I have NOT had the Hepatitis B vaccine series and need information on how to get it.
- I do not want to have the TB skin test and/or Tetanus/Diphtheria vaccine
- Other \_\_\_\_\_

Profession:

Physician:  MD  DO

Dentist:  DDS  DMD

Physician's Assistant

Nurse Practitioner

Registered Nurse

Licensed Practical Nurse

Registered Dental Hygienist

Pharmacist

Other: \_\_\_\_\_

Specialty/Area of Practice:  
\_\_\_\_\_

Dispensing License:

Yes  No

Board/Specialty Certification:

Active  Inactive  Restricted

AZ License Number:  
\_\_\_\_\_

AZ License Expiration Date:  
\_\_\_\_\_

Church Attending:  
\_\_\_\_\_

Have you ever been subject to disciplinary action by a professional State Board?

No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Have there ever been, or are there currently pending, any malpractice claims, suits, or settlements, or arbitration proceedings, or complaints filed involving your professional practice within the past five (5) years? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, describe nature of incident, date, outcome, and insurance company for the claim.

I certify that the information provided above is accurate. I understand I have the right to terminate my volunteer status at any time for any or no reason, as long as I do not terminate in a fashion to jeopardize a particular patient; and the Clinic has the right to terminate my volunteer status for any or no reason at any time.

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

**Professional Liability Insurance:**

All physicians, nurse practitioners, and physician assistants volunteering in the Clinic are required to carry a minimum of \$1 million per occurrence in malpractice insurance. Nurses and pharmacists are covered by the Clinic insurance policy and are not required to carry additional coverage. If your malpractice insurance will not cover your work at The Neighborhood Christian Clinic, TNCC can arrange coverage for you.

\_\_\_\_ I will not be able to obtain the required malpractice insurance through my own insurance provider.

\_\_\_\_ I have the required malpractice insurance through my own insurance provider and I have attached a copy of the Certificate of Insurance.

**Physicians / Nurse Practitioners / Physician Assistants / Dentists**

Please provide copies of the following:

- \_ AZ driver's license or passport with picture identification
- \_ AZ professional license/certificate to practice
- \_ Copy of Diploma from medical, dental, advance practice programs
- \_ DEA certificate (if applicable)
- \_ Professional liability certificate of insurance (minimum \$1 million per occurrence and \$3 million aggregate), policy number and limits of liability
- \_ Dispensing License (if physician), (if none, please ask for the BOMEX form. The fee is waived)
- \_ 2 recent letters of reference -1 of which is from a professional source

**Others:**

Please provide copies of the following:

- \_ AZ driver's license or passport with picture identification
- \_ AZ professional license to practice
- \_ Copy of diploma from professional studies
- \_ 2 recent letters of reference - 1 of which is from a professional source

## The Neighborhood Christian Clinic VOLUNTEER INFORMATION

**Days of the week available to volunteer:**

**(Note: Morning Shift 9:00am-12:00pm, afternoon shift 1:00pm-5:00pm & evening shift 6:00pm – 9:00pm)**

Mon afternoon\_\_\_ Mon evening\_\_\_ Tues morning\_\_\_ Tues afternoon\_\_\_  
Thurs afternoon\_\_\_ Thurs evening\_\_\_ Friday morning\_\_\_ Friday afternoon\_\_\_

**How often would you like to volunteer?**

\_\_\_ Weekly     \_\_\_ Twice a month     \_\_\_ Monthly     \_\_\_ Other \_\_\_\_\_

**How did you hear about TNCC?**

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### **(2) REFERENCES:**

**Please submit 2 reference letters or emails to [cmccourt@tnclinic.org](mailto:cmccourt@tnclinic.org) providing the answers to the following questions.**

- 1. The amount of time the person has known you and in what capacity.**
- 2. What your strengths are.**
- 3. Are you dependable? Flexible?**
- 4. How well do you get along with other people?**
- 5. What is their perception of your overall attitude?**
- 6. Do they know of any reason why you should not volunteer with TNCC?**

Have you been convicted of a felony or misdemeanor: Yes \_\_\_\_ No \_\_\_\_

If YES, please explain the conviction and penalty. Please write on the back if more space is needed.

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**The Neighborhood Christian Clinic, Inc. will operate under the following mission statement and statement of faith. If you support them, please sign and return with your application. Thank you.**

**The Mission of The Neighborhood Christian Clinic, Inc is threefold as follows:**

- 1. To provide medical and dental healthcare services to the uninsured, underserved community**
- 2. To share the Gospel and love of Jesus Christ with interested patients and colleagues**
- 3. To train and equip healthcare professionals to share the Gospel and love of Jesus Christ in their daily practice.**

**Statement of Faith:**

**The Bible to be the inspired, only infallible, authoritative Word of God:**

**There is one God, eternally existent in three persons, Father, Son and Holy Spirit:**

**In the deity of our Lord Jesus Christ, in His virgin birth, in His sinless life, in His miracles, in His atoning death through His shed blood, in His bodily resurrection, in His ascension to the right hand of the Father, and in His personal return in power and glory;**

**For the salvation of the lost and sinful men, we must each individually receive Jesus Christ as Savior and Lord;**

**That regeneration by the Holy Spirit is absolutely essential;**

**In the present ministry of the Holy Spirit by whose in-dwelling the Christian is enabled to live a godly life.**

**In the resurrection of both the saved and the lost. They that are saved unto the resurrection of eternal life and they that are lost unto the resurrection of eternal separation from God; Man's ultimate purpose is to glorify God.**

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Signature

**HIPPA and The Neighborhood Christian Clinic Volunteers:**

**What you need to know.....**

- ❖ **As a TNCC volunteer, you may have access to confidential medical information. The fact that a patient is at TNCC is even confidential information.**
- ❖ **Federal and state laws and TNCC protect this confidential information**
- ❖ **It is illegal for you to use or disclose this confidential medical information outside the scope of your volunteer duties at TNCC. This includes verbal or written disclosure.**
- ❖ **Guidelines for the use of this information:**
  - **You may use this information as necessary in the contact with patients.**
  - **Do NOT photocopy patient information.**
  - **Do not photograph patients.**
  - **Access the minimum amount of information necessary to carry out your volunteer assignment.**
  - **Do not record patient names, dates of birth, address, phone number, social security number, etc – on forms leaving the clinic.**
  - **You may only access the confidential information of patients for whom you are volunteering when there is a need for the information.**
  - **Be aware of your surroundings when discussing confidential information. It is inappropriate to discuss patients where others may overhear.**
  - **If you have questions about the use or disclosure of confidential health information, contact your volunteer coordinator.**
  - **When disposing of any documents with (patient information) do not put into a waste can. Place instead in the shredding containers.**

**I have read and understand the information in this brochure. I realize that there are civil and criminal penalties for the unauthorized use and disclosure of confidential patient information. I will abide by the guidelines when performing my volunteer duties.**

\_\_\_\_\_  
**Signature of volunteer**

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

\_\_\_\_\_  
**Date**