Volunteer Application and Waiver

Personal Information

Name: (Last, First, Middle Initial)_____
Nickname: _____ Alternate Name (If Applicable): _____
Street Address:_____ City, Zip, County:_____
Home Phone: _____ Cell Phone: _____
Email Address:_____

Emergency Contact Information
Full Name:_____ Relationship:_____
Home Phone: _____ Work Phone: _____
Email: _____ Cell: _____
Street Address: _____ City, State, Zip: _____

Education
High School:_____
Undergraduate School: _____ Degree:_____ Major:_____
Graduate School:_____ Degree:_____ Major: _____
Other: _____

Employment Information

□ Student □ Employed □ Not Employed □ Not Employed at this time □ Retired

Employer:_____
Department:_____ Title:_____
Street Address:_____ City, State, Zip:_____

Availability to Volunteer—Volunteer times are limited. Please check all times that apply.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
□ Mornings	□ Mornings	□ Mornings	□ Mornings	□ Mornings	□ Mornings	□ Mornings
□ Afternoons	□ Afternoons	□ Afternoons	□Afternoons	□Afternoons	□ Afternoons	□ Afternoons
□ Evenings	□ Evenings	□ Evenings	□ Evenings	□ Evenings	□ Evenings	□ Evenings

Comments on Availability: _____

How did you hear about volunteering at Every Child Pediatrics? _____
_____

Do you smoke? □ Yes □No

Volunteer Position of Interest:_____
Reason: _____

Are you related to a Every Child Pediatrics' staff member?: □ Yes □ No
If yes, please list name(s): _____

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HIPAA and Mandatory Reporting
All volunteers at Every Child Pediatrics are considered mandatory reporters and must report any cases of suspected abuse in patients. All Every Child Pediatrics volunteers are bound by HIPAA laws. All volunteers will receive orientation regarding in both HIPAA and Mandatory Reporting before being allowed to volunteer.

Medical Insurance
Please attach a copy of your medical insurance card. Every Child Pediatrics cannot accept volunteers without medical insurance.

Medical Care
Under no circumstances will medical care be provided by volunteers.

Image Release
I hereby grant Every Child Pediatrics the rights to use my image and any other interactions at Every Child Pediatrics for Every Child Pediatrics displays, publicity, educational programs, and/or public relations. The above will not be used for retail sale or retail products.

Disclosure
Have you ever been convicted of any felony (except minor traffic violations)? □ Yes □ No

If so, please provide disposition of case: _____

Authorization for Background Check (to be completed by applicants over 18)
As an applicant for a volunteer position with Every Child Pediatrics, I realize that a thorough background check is conducted to qualify me for volunteering. I understand that Every Child Pediatrics must verify my date of birth and social security number. I hereby authorize the release of any information relating to my criminal history, and any additional specific information relating to the position that I am applying for, unless restricted by law. This authorization is made voluntarily, for the purposes of volunteering only, and information should be given only in response to an authorized request from Every Child Pediatrics. Authorization by: Full name (First, Middle, Last):

_____

Known by Any Other Name:_____

□ Male □ Female Date of Birth:_____ Social Security No:_____

Release and Waiver
I understand that as a volunteer I agree to submit to the appropriate background checks required by Every Child Pediatrics. I understand that I may be working with children or other volunteers, may be required to lift items up to 15 lbs., or be required to sit for extended periods or walk around the clinic. I may be exposed to sick children. I may see confidential medical records and understand that I am bound under the HIPAA privacy laws. By submitting this application to become a Every Child Pediatrics volunteer, I (or my legal guardian if I am under 18 years of age) state that I am capable of performing these tasks and waive and release any and all claims I may have against Every Child Pediatrics, it's medical staff, employees or other volunteers based on any injuries or damages that I may incur in the course of volunteering. I also understand and agree that being a volunteer does not mean I am a Every Child Pediatrics employee. I don't expect that volunteering will lead to or becoming employment, and understand that I am not entitled to any employee benefits such as workers compensation, salary, or any other benefit of compensation.

Signature
By signing your name below, you are authorizing Every Child Pediatrics to conduct a background check, and represent that the information provided is true and correct and that you have read and will abide by the terms and conditions contained in the application.

_____ _____ _____

Print Name | Signature of Applicant (or guardian) | Date