



Dear Volunteer Candidate:

Thank you for your interest in volunteering at HealthLink. As you know, we are very much in need of volunteers to help with administrative tasks as we care for the increasing numbers of uninsured patients who seek our dental services.

I am enclosing a number of forms for you to complete and return so that we may begin the approval process. In addition to the application, I will also need you to provide the following:

- A copy of photo identification

Again, thank you for considering sharing your valuable time at HealthLink.

Please call if you have any questions. We look forward to working with you.

Sincerely,

Neil Gordon, MBA  
*Interim Executive Director*

# Student Volunteer Application



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

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

Phone #: \_\_\_\_\_

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

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

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

\_\_\_\_\_

\_\_\_\_\_

---

Social Security #: \_\_\_\_\_

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

---

Employer (if any) & how long? \_\_\_\_\_

Work #: \_\_\_\_\_

Fax #: \_\_\_\_\_

---

Local emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency contact phone #: \_\_\_\_\_

---

Foreign language(s) spoken fluently:  Spanish  Other: \_\_\_\_\_

How were you referred to HealthLink? \_\_\_\_\_

Best way to contact you:  Cell  Email

How did you hear about this opportunity?

## Student Volunteer Application

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time:					

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.

Signature \_\_\_\_\_

Date \_\_\_\_\_

---

## Education Information:

Undergraduate school (if applicable)

\_\_\_\_\_

Major: \_\_\_\_\_

Year of graduation: \_\_\_\_\_

Graduate school (if applicable):

\_\_\_\_\_

Major: \_\_\_\_\_

Year of graduation: \_\_\_\_\_

- 
1. Best way to contact you:       Work       Home       Cell
  2. Where would you prefer to receive HealthLink correspondence?       Work       Home
  3. Preferred scheduling method of contact: Ground Mail:       Home       Work       Email
-

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

## 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 medical, surgical, 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>

---

*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 HealthLink's greatest assets. The scheduling of volunteers is therefore tremendously important.

My signature below implies my understanding of this policy.

---

---

Volunteer Printed Name

---

Volunteer Signature

---

Date