HEALTHLINK
DENTAL CLINIC
FREE dental care for qualified adults

Dear Volunteer Candidate:

Thank you for your interest in volunteering at HealthLink. As you know, we are very much in need of professional volunteers to 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 credentialing process. In addition to the application and credentialing information, I will also need you to provide the following:

- Copies of your professional licenses and certifications
- A resume or Curriculum Vitae
- A copy of photo identification
- Evidence of malpractice coverage or volunteer license if you are retired
- Verification of TB testing and results within the past year, and
- Verification of Hepatitis B immunization if your volunteer activity at HealthLink will involve exposure to blood and body fluids.

Again, thank you for considering sharing your valuable time and expertise at HealthLink. Please call if you have any questions. We look forward to working with you.

Sincerely,

Neil Gordon, MBA
Interim Executive Director

Dental 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 HLMC? _____

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

How did you hear about this opportunity?

Dental Volunteer Application

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday
	☐	☐	☐	☐	☐
Time:					

Preferred method of scheduling contact: Ground Mail: ☐ Home ☐ Work
☐ Email

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

Credentialing Information:

Social Security #: _____

Date of Birth: _____

Undergraduate school:

_____

Professional school of study:

_____

Year of graduation: _____

License #: _____

Certification #: _____

Areas of certification:

_____

Areas of practice:

_____

---

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: _____

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 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 no 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 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 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 ground mail along with a calendar for the months in question. Volunteers are asked to respond with their availabilities no less than 2 weeks prior to a given month, and must notify the receptionist 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 of any additions or changes immediately.

My signature below implies my understanding of this policy.

_____

Volunteer Printed Name

_____

Volunteer Signature

_____

Date