samaritan
HEALTH MINISTRIES

..... FOR OFFICE USE ONLY .....

Date Received: _____ Orientation Date: _____ Start Date: _____ Volunteer Type: _____

Volunteer Contact List: ☐ Background Ck: ☐ SHM Database: ☐ Email / Distribution Lists: ☐ Processed By: _____

For Practitioners: *Date Reviewed:* _____ *Approved: Y / N* _____ *Medical Director:* _____

VOLUNTEER APPLICATION

We consider applicants for all volunteer positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

PERSONAL INFORMATION

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

E mail Address: _____ SSN: _____

VOLUNTEER SERVICES

Please mark "X" in the area in which you are licensed and provide your license number:

1. ☐ Physician (MD, DO) - License #: _____ NPI #: _____
2. ☐ Family Nurse Practitioner (FNP) - License #: _____
3. ☐ Physician Assistant (PA) - License #: _____
4. ☐ Clinical Nurse Specialist - License #: _____
5. ☐ Nurse (RN, LVN) - License #: _____
6. ☐ Pharmacist (RPh) - License #: _____
7. ☐ Pharmacy Technician - License #: _____
8. ☐ Dentist - License #: _____
9. ☐ Dental Assistant - License #: _____
10. ☐ Dental Hygienist- License #: _____

Please mark "X" in the area you have skills or interest:

11. ☐ Patient Registration/Office
12. ☐ Daytime Projects (clerical)
13. ☐ Spanish Interpreter
14. ☐ Other: _____

Please list your Occupation / Specialty: _____

Do you have privileges at any local hospital(s)? _____

LANGUAGE SKILLS

Do you speak fluent Spanish? ☐ Yes ☐ No ☐ Some ☐ Other Language: _____

SCHEDULE PREFERENCES

Preferred day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

How often? ☐ 1x Week ☐ 1x Month ☐ 2x Month ☐ 1 x every other month

☐ I am interested in a set schedule

VOLUNTEER EXPERIENCE / GOALS

Have you volunteered elsewhere? If so, where? _____

Why do you want to volunteer at Samaritan Health Ministries?

_____

Please list any other skills or experience (such as website design, marketing, writing, fundraising)

_____

How did you hear about us? _____

REFERENCES

Name & Phone : _____ Name & Phone: _____

CONVICTION RECORD STATEMENT

Have you ever been convicted of, or received deferred adjudication for, a crime? ☐ Yes ☐ No

If yes, please explain: _____

AGREEMENT

I (print full name)_____ authorize any inquiry to be made on any information contained in this application if I am considered for volunteer placement which will include a background check. I understand that all files and records maintained by the Samaritan Health Ministries (SHM) are privileged and confidential. Any and all information that I may have access to may not be released or communicated to others unless authorized by the Executive Director or staff member who has also been authorized by the Executive Director to make that determination. I understand that I will be expected to treat all patients, volunteers and staff with respect. I understand and consent that any photos or video taken of me while at the Clinic can be used for Clinic purposes. I acknowledge my understanding of the conditions of my voluntary service for the SHM and acknowledge and understand that I must conform to the rules and regulations of the SHM to the best of my ability or my voluntary services may be terminated.

Signature:_____ **Date:** _____

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , have been notified that a Computerized Criminal
APPLICANT or EMPLOYEE NAME (Please print)
History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply.

Because the name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization conducting the criminal history check for background screening is not allowed to discuss any criminal history record information obtained using the name and DOB method. Therefore, the agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (Automated Fingerprint Identification System). I have been made aware that in order to complete this process I must make an appointment with L1 Enrollment Services, submit a full and complete set of my fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company, L1 Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ _____ initial

Purpose of CCH: _____

Hire ☐ Not Hired ☐ _____ initial

Date Printed: _____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

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