Application for Service
(Non-Clinical)

805 S. Northshore Drive
Knoxville Tennessee 37919
Tel: (865) 212-5570
Fax: (865)766-2650

We consider applicants without regard to race, color, religion, sex, national origin, age, disability, or any other legally protected status.

Dear St. Mary's Legacy Clinic Volunteer:

Thank you for your interest in volunteering with St. Mary's Legacy Clinic (SMLC)! We are grateful for your desire to help those most in need of healthcare in East Tennessee. The SMLC application packet contains the following:

1) Application Form with Acknowledgements
2) Emergency Contact Information
3) Fair Credit Act Disclosure Form
4) Confidentiality Agreement

Please send all completed forms by email, mail, or fax to:

Volunteer Coordinator
St. Mary's Legacy Clinic
805 S. Northshore Drive
Knoxville, TN 37919-7557
Bvinyard@smlcares.com

Because we are a ministry of the Catholic Church, all employees and volunteers must complete the safe environment training through CMG Connect. To register, please go to cmgconnect.org. CMG Connect also completes your background check (costs are covered by SMLC, so please click “Paid by Dioceses” when asked about payment).

If you have any questions throughout the application process and/or would like further instructions, please contact the SMLC office. During the SMLC small-group volunteer orientations, we discuss the Clinic mission and operations. To sign up for orientation, please call St. Mary's Legacy Clinic and ask for the Administrative Assistant or Nurse Manager.

Thank you for your interest in helping bring the healing ministry of Jesus to the most vulnerable of East Tennessee. We look forward to serving with you!

Respectfully,

St. Mary's Legacy Clinic Staff

Volunteer Application

Date: ____/_____/______

Name (first and last): ____

Preferred Clinic Site (if known): ____________________________________

Applying for the following volunteer position(s):

- ❑ Physician ____________________________
  Area of Specialty
- ❑ Nurse _______________________________
  Area of Specialty
- ❑ Other Healthcare Professional ___________________________
  Area of Specialty
- ❑ Driver (requires Class B CDL with airbrakes)
- ❑ Translator
- ❑ Patient Registration
- ❑ Hospitality
- ❑ Office Assistant
- ❑ Fundraising/Special Events
- ❑ Other: ________________________________

Contact us: (865) 212-5570
www.stmaryclinic.org

Volunteer Application

First Name	Middle Name	Last Name	Highest education level achieved

Address	City	State	Zip

Date of Birth	Cell Phone	Home Phone	Email

Current volunteer work and/or employer:	Language(s) spoken:
Other pertinent/relevant trainings or experiences:	

Do you have any physical limitations or medical problems that might restrict your volunteer activities? Yes No

If yes, please explain.

How far from home are you willing to travel to a Clinic site? Are there specific Counties to which you are willing to go?

Which days work best for you to volunteer?	How often would you be able to volunteer?	If necessary, would you be able to work on short notice?
❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday	❑ Once a week ❑ Twice monthly ❑ Monthly ❑ Other	Yes No If yes, how much notice would you need? _______________

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Acknowledgements

- I certify that all entries on this application are true, and I consent to references (physicians only) being contacted regarding this application.
- I acknowledge that I must comply with the Diocese of Knoxville's Safe Environment program, which includes:
  - A basic background check every 5 years;
  - Completion of the online *Safe Haven - Safe Environment* through CMG Connect; and
  - Reading and signing the diocesan sexual misconduct policy through CMG Connect.

  If applying to be a clinic driver, additional background checks may be required.
- Depending on my position, I may be asked to provide copies of:
  - Current professional license*;
  - Class B commercial drivers' license and medical certificate

Signature Date

Printed Name

**Retired professionals who do not maintain a full active license may be able to obtain a special volunteer license. Please check with your state licensing board for an application.*

ALL CURRENTLY LICENSED HEALTH CARE PROFESSIONALS:

- My professional health care license has not been suspended or revoked in any State or Territory of the United States.

Signature Date

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Emergency Contact Information

Volunteer Name (first and last): ____

Please list two persons whom we may contact in case of emergency:

Name of emergency contact #1: ____

Relation to volunteer: ____

Phone number: ____

Email address: ____

Name of emergency contact #2: ____

Relation to volunteer: ____

Phone number: ____

Email address: ____

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Fair Credit Reporting Act Disclosure Regarding Consumer Reports and Investigative Consumer Reports

THIS FORM IS NOT A CONSENT FOR A BACKGROUND OR CREDIT CHECK. IT IS FOR INFORMATIONAL AND DISCLOSURE PURPOSES ONLY.

When St. Mary's Legacy Clinic ("the Clinic") is

- considering your application for employment;
- making a decision whether to offer you employment;
- deciding whether to continue your employment (if you are hired) or volunteer service (if accepted); and
- making other employment-related decisions directly affecting you,

you will be required to consent to a background check. Background checks are called "consumer reports" or "investigative consumer reports" in the Fair Credit Reporting Act ("FCRA"), which dictates how consumer reports and investigative consumer reports can be used. As an applicant for employment or for volunteering, or an employee of the Clinic, you are a "consumer" with rights under the FCRA. As a user of consumer reports, the Clinic is required to provide you this disclosure form.

A "consumer report" is any written, oral, or other communication of any information by a "consumer reporting agency" bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or collected for the purpose of serving as a factor in establishing the consumer's eligibility or continued eligibility for employment purposes. An "investigative consumer report" may include information as to your character, general reputation, personal characteristics, and mode of living, which may be obtained by contacting your previous employers and/or references, associates, or others. Before the Clinic runs any consumer report or investigative consumer report, you will be asked to sign a separate authorization and consent form, which will provide a listing of the specific background screens which may be performed (e.g., criminal background checks, credit checks for positions with access to money or other personal property, etc.).

If the Clinic obtains a report on you, and if it considers any information in the report when making an employment or volunteer-related decision that directly and adversely affects you, you will be provided with a copy of the report before the decision is finalized. You may also contact the Consumer Financial Protection Bureau about your rights under the FCRA as a "consumer" with regard to "consumer reports" and "consumer reporting agencies."

You have the right to request, in writing within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested. Such disclosure will be made to you within 5 days of the date on which we receive the request from you or within 5 days of the time the report was first requested, whichever is later.

Please sign below to confirm that you received, read, and understood the terms of this Disclosure Form.

____

Applicant's Name (print)

____

Signature   Date

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ST. MARY'S LEGACY CLINIC

CONFIDENTIALITY AGREEMENT

I, ____________________________________, as a professional or general volunteer working at the St. Mary's Legacy Clinic shall maintain the privacy and confidentiality of all information relating to patients of the clinic. I shall not disclose patient information to any third party other than St. Mary's Legacy Clinic, including a volunteer participating in the clinic that does not have a need to know the patient information. I shall not use patient information for any purpose other than patient follow-up and evaluation, and after complying with the obligations set out, shall not retain any patient information, except that which is needed for clinic records, for patient registration, or follow-up care.

____

Signature Date

____

Witness Date

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Thank you for completing the SMLC Volunteer Application!

Volunteer Onboarding Checklist:

Required Documents (all volunteers):	Date
SMLC Application Form with Acknowledgements	
CMG Connect, includes: 1. Background Check 2. Safe Environment Training	 ______________ ______________
Emergency Contact Information	
Fair Credit Act Disclosure Form	
Confidentiality Agreement	
Job Description (when applicable)	
Received Name Badge +/- Athena Login Info	

Please let us know if you have any questions.

We look forward to serving with you!

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