Medical Provider Application for Service

St. Mary's Legacy Clinic

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.

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

St. Mary's Legacy Clinic

Dear Potential Volunteer of St. Mary's Legacy Clinic:

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
5) Acknowledgement of Ethics Policy
6) Release and Indemnification Statement
7) Declining of Hepatitis B Vaccine
8) Healthcare Background and References

Please send all completed forms by email, mail, or fax to:
Bri Vinyard
St. Mary's Legacy Clinic – Volunteer Coordinator
805 S. Northshore Drive
Knoxville, TN 37919-7557
info@dioknox.org

Additionally, please provide a **current CV, a copy of your medical license, and if available, a letter verifying hospital privileges**. If you do not have current hospital privileges, please run a **National Practitioner Data Bank Self Query** and send this report.

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

St. Mary's Legacy Clinic

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: _____

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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 day(s) 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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***With your application, please include a copy of your current **CPR certification**. CPR recertification may available if/when needed.*

Acknowledgements

- I certify that all entries on this application are true, and I consent to references 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*;

_____

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.

_____

St. Mary's Legacy Clinic

Signature

Date

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: _____

St. Mary's Legacy Clinic

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.

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_____

Applicant's Name (print)

_____

Signature Date

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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Acknowledgement of Ethics Training and Policy

1. I acknowledge that St. Mary's Legacy Clinic has adopted the Ethical & Religious Directives (ERD's) for Catholic Healthcare Services, 5th ed (or most current edition) as promulgated by the United States Conference of Catholic Bishops and that I have received training on these Directives.

2. I further acknowledge that I will conform my practice within the Clinic to the Ethical and Religious Directives and to the appropriate moral teachings of the Catholic Church.

_____

Signature Date

_____

Print Name

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RELEASE AND INDEMNIFICATION STATEMENT

I hereby release and indemnify St. Mary's Legacy Clinic, a non-profit organization, and all its respective officers, directors, agents, contractors, successors, and assigns, any claim for bodily injury or death or for property loss or damage incurred by me in connection with St. Mary's Legacy Clinic or related activities including those resulting from negligence.

_____

Signature Date

_____

Print Name

_____

Witness Signature Date

_____

Witness Print Name

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DECLINING OF HEPATITIS B VACCINE

(MANDATORY FOR PROFESSIONALS)

I fully understand that I am volunteering at my own risk and that due to my occupational/other possible exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection or other blood borne pathogens. I agree that if exposed to blood borne pathogens or other potentially infectious materials during clinic visits, I will follow the guidelines recommended by the Centers for Disease Control regarding post exposure treatment. I understand that failure to follow the guidelines in the event of an exposure during the course of work significantly increases my chances of infection.

Please sign one below:

I have received the vaccination for Hepatitis B

_____

Signature Date

I have not received the vaccination for Hepatitis B and I hereby waive having this vaccination of my own free will. I understand if I do not have the HBV vaccination, I can be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I want to be vaccinated with the Hepatitis B vaccine, I can acquire the vaccination at my own expense and understand that my immunization series should be completed at least 6 months before I plan to volunteer.

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Signature Date

Witness Signature Date

Previous or Current

Hospitals and/or Clinics in which you have worked:

	Please provide the name(s) of the hospital(s) and/or clinic(s) at which you have worked in the last five years.	
	Name of hospital or clinic	
	City, State	Dates
	Name of hospital or clinic	
	City, State	Dates

	Please provide the name(s) of the hospital(s) and/or clinic(s) at which you have worked in the last five years.

St. Mary's Legacy Clinic

	Name of hospital or clinic	
	City, State	Dates
	Name of hospital or clinic	
	City, State	Dates

Professional References

Please include only non-family members for professional references.

Applicant Name: _____

1) Reference Name and Relationship to Applicant
Phone Number

2) Reference Name and Relationship to Applicant
Phone Number

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FOR OFFICE USE ONLY:

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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)	
Required Documents (clinical volunteers):	
Bloodborne Pathogens Training (via CMG)	
Acknowledgement of Ethics Policy	
Release and Identification Statement	
Declining of Hepatitis B Vaccine	
CPR Certification	
Healthcare Background Information	
Professional References (physicians only)	
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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