APPLICATION FOR CLINICAL VOLUNTEER SERVICE

Return completed application to:

Medical Mission Adventures
11540 Bonham Ave.
Sylmar, CA 91342
Email: mma@mmadventures.org
Fax: 818-890-3656

Please fill out completely before submitting. We cannot process your application for volunteer service unless all pertaining sections are completed and we receive all supporting documentation listed within this application.

PERSONAL INFORMATION:

Name: (Last)_____(First)_____(MI) _____

Gender:____M____F Marital Status:____Single____Married Date of Birth: _____

Driver License *(please attach)*: _____ Expiration Date: _____

Home Address: _____
Street City State Zip Code

Home Phone: _____ Email: _____

Cell Phone: _____ Fax: _____

Emergency Contact (Name):_____Phone: _____

AREA(S) OF INTEREST:

Clinical:

_____Family Practice Doctor
_____Specialty Doctor
_____Physician Assistant
_____Nurse Practitioner
_____RN
_____Dentist
_____Optometrist
_____Pharmacist
_____Other _____

Other:

_____Patient Intake
_____Patient Records
_____Wherever Needed
_____Prayer Partner
_____Patient Follow up
_____Coordinate Volunteers
_____Help with fundraising

REFERENCES:

1. _____
   Name Relationship
   _____
   Address
   _____
   Phone Email

2. _____
   Name Relationship
   _____
   Address
   _____
   Phone Email

TYPE OF PRACTICE:

___Dental ___Optical ___Medical ___Specialty _____

___Nurse (type) _____ ___Other _____

PRIMARY PRACTICE INFORMATION (nurses included)**:**

Practice Name: _____

Practice Address: _____

_____

Mailing address if different from above:

_____

_____

Phone: _____ Email: _____

Practice Manager: _____

SECONDARY PRACTICE INFORMATION, if applicable:

Practice Name: _____

Address: _____

_____

Phone: _____ Email: _____

Practice Manager: _____

FACILITY AFFILIATIONS (nurses included)**:**
(List current hospital/health system affiliation where you have been credentialed and privileged)

Facility Name: _____

Address: _____

Department/Service/Position: _____

Dates of Appointment: From _____ To _____

SCHOOL OF STUDY/TRAINING/SPECIALTY:

Institution: _____

Location (city & state): _____

Type of Training/Specialty: _____ Date of Graduation: _____

*Full Name by which you were enrolled: _____

INTERNSHIP:

Institution: _____

Address: _____

Type of Training/Specialty: _____ Date of Completion: _____

Full Name during internship: _____

RESIDENCY:

Institution: _____

Address: _____

Type of Training/Specialty: _____ Date of Completion: _____

Full Name during residency: _____

LICENSURE & REGISTRATIONS *(List all active professional licenses)**:**

State	Type	Number	Date of Issue	Expiration Date
State	Type	Number	Date of Issue	Expiration Date
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Federal DEA number _____ (UPIN) _____

CERTIFICATIONS:

Specialty:_____

Board Certified? Name of Board: _____

Certification ID Number: _____ Expiration Date: _____

National Certification? Y N Name of Organization: _____

Certification ID Number: _____ Expiration Date: _____

IMMUNIZATION HISTORY (Please provide dates of immunization):

MMR _____ Hepatitis B _____ Influenza _____ Tdap (one time) _____

Varicella _____ Last dT booster _____ PPD (Tuberculosis) _____

CLAIMS INFORMATION:

Have you ever been denied professional liability insurance, or has your coverage ever been canceled?

☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

_____

Are there currently pending or have there been any malpractice claims, judgments or settlements involving your professional practice in the last 3 years? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

_____

_____

_____

_____

REQUIRED COPIES & REFERENCES:

Copies of the following documents must be provided with this application:

- Driver license
- Immunization and TB skin test result status
- Professional license and any certifications
- DEA registration, as applicable
- BLS certification
- Current C.V.

STATEMENTS OF AFFIRMATION:

I affirm that:

- I have never been convicted of a felony
- I have never been charged with sexual harassment
- I have not and will not provide patient care under the influence of drugs or alcohol
- I do not have any communicable disease, and I further understand that if at any time I am considered to be infectious I will notify the Clinic's medical director and/or executive director

In making this application, I acknowledge my obligation to:

- fulfill my responsibilities to provide continuous quality care to patients of the Clinic
- make decisions as appropriate to the patient's needs, to maintain practice knowledge and skills through continuing education opportunities
- abide by the bylaws, rules and regulations, policies and procedures of the Clinic
- participate in and cooperate fully with the Quality Assurance Program and all programs to improve quality and reduce risks

I agree to:

- participate in the review of records and documents relating to patient care and services
- subject my performance to review by the Clinic and its representatives for the purpose of improving the quality of care and services and reducing risk.

I hold the Clinic and its representatives free of all liability for such actions.

_____
Applicant's Name (print)

_____ _____
Applicant's Signature Date

CONFIDENTIALITY AGREEMENT

In consideration of my volunteerism with Medical Mission Adventures, Inc. (hereafter referred to as MMA), I recognize that confidentiality is vital to protect the privacy of our patients and staff. Also included are any issues that relate to the patient and staff. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with all MMA activities whether oral, electronically, or written, and I understand that by signing this agreement I am binding myself by contract to maintain such confidentiality. I agree that I will not make any voluntary disclosure of such confidential information outside of MMA, limit dissemination of such confidential information to only those MMA employees/volunteers who have a need to know to perform their assigned tasks, not copy confidential information or any portion thereof except as required under my assigned duties, and return all such confidential information and any copy thereof upon termination of my service with MMA.

I understand and agree that MMA shall have the right to seek and obtain from a court of competent jurisdiction, in an action for that purpose, an order and /or a judgment enjoining and prohibiting me from voluntarily disclosing confidential information in violation of this agreement. I agree that it is impossible to measure in money the damages which would result from my disclosure of confidential information in violation of this agreement and that irreparable injury would be caused thereby to MMA. I hereby waive any claim of defense that MMA has an adequate remedy at law, and I consent to the imposition of injunctive relief to prevent a breach of this agreement. MMA shall be entitled to recover attorney's fees and court costs from me in any such action in which they are successful.

I understand that my obligations under this agreement will continue whether or not my service with MMA is terminated voluntarily, or with or without cause and shall continue to bind my successors, heirs, and assigns.

This agreement may not be changed in any detail by any verbal statement, representation, or other Agreement made by any other MMA employee or volunteer, or by any written document signed by any MMA employee/volunteer other than a MMA officer.

The law of the state of California will govern the interpretation, validity, and effect of this contract, without regard to the place of making or the place of performance.

Further I state that: (a) I am legally competent to execute this agreement and I am above the age of eighteen (18) years of age; (b) No promise or agreement which is not expressed has been made to me in executing this release; (c) I am not relying upon any statement or representation of any agent of the parties being released; (d) I understand that the terms of this release are contractual and not mere recital; (e) I have had the opportunity to consult with legal counsel regarding the effect of this agreement and release should I so desire; and (f) I have fully read this release and have agreed to as my own free act and will.

_____

Applicant's Name (print)

_____ _____

Applicant's Signature Date

AUTHORIZATION AND CONSENT

I give my permission to Medical Mission Adventures, Inc. to verify any information necessary pertaining to my volunteer application. I hereby release from liability Medical Mission Adventures and all its representatives for their acts performed while evaluating my application, credentials and qualifications, including the gathering of necessary information from primary sources for the verification of professional credentials.

I hereby release from any liability any and all individuals and organizations that provide information to Medical Mission Adventures or its representatives concerning my professional competence, character, ethics, credentials and other qualifications for employment and/or privileges, and I hereby consent to the release of such information.

As applicable, I hereby accept that I will abide by the requirements for medical malpractice coverage for the Federal Tort Claims Act. I will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims.

I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. I fully understand that any misstatements or omissions in the application constitute cause for denial or termination of privileges. All information submitted by me in this application is true to the best of my knowledge.

_____

Applicant's Name (print)

_____ _____

Applicant's Signature Date

Thank you for applying to volunteer with Medical Mission Adventures, Inc.!