Providence
Medical Clinic of Kingsport

441 Clay St; Kingsport TN 37660
Mailing Address: PO Box 1323; Kingsport TN 37662

VOLUNTEER APPLICATION

Office Support Staff & Spiritual Support Staff

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

(Volunteers will receive clinic schedules and announcements via email. Please notify the office if you prefer another method of contact.)

How did you hear about Providence Medical Clinic? _____

I AM INTERESTED IN VOLUNTEERING AT THE CLINIC IN THE FOLLOWING CAPACITY:

____ Office Support Staff
____ Spiritual Support Staff

WHEN ARE YOU INTERESTED IN WORKING?

Providence Medical Clinic will be open the doors every Thursday evening from 4:30 p.m. until 5:30 p.m.
Daytime office hours will be Tuesday, Friday; 9:00 a.m. – 1:00 p.m.
(No patient exams during daytime hours.)
1. How often would you like to volunteer at the clinic?
___Once a month ___Every two months ___ As needed
2. For Office Staff - do you prefer ____ evenings ___ daytime – indicate day _____

TELL US ABOUT YOUR INTEREST IN CHRISTIAN MINISTRY:

I attend the following church: _____
Pastor's Name: _____ Church Phone #:_____
Please tell us why you would like to be a part of the ministry at Providence Medical Clinic:

_____
_____
_____
_____
_____
_____

PLEASE HAVE YOUR PASTOR COMPLETE THIS SECTION:

I have known _____ for ____ years or ____ months, and
recommend him/her as a volunteer for Providence Medical Clinic.
Pastor's Signature: _____ Date: _____
Church _____

_ _

PLEASE PRAYERFULLY CONSIDER AND SIGN:
******In submitting this application to serve as a volunteer at PMCK, I agree to support the clinic vision statement *Providence Medical Clinic of Kingsport offering compassionate medical and spiritual care to the underserved residents of the Greater Kingsport Area.*

Signed: ____ Date: ________________

Received by: ____ Date: ________________

_ _

FOR OFFICE USE ONLY:
1. Applicant has attended orientation/training session? __ Y or __ N If yes, when___________
2. Applicant is assigned to following duties: ____
3. Applicant has been contacted with initial schedule? __ Y or __ N If yes, when___________
4. Applicant has signed the PMCK Confidentiality Agreement? __ Y or __ N

Providence
Medical Clinic of Kingsport
441 Clay St; Kingsport TN 37660
Phone: 423-247-4536 Fax: 423-247-5676

Confidentiality Agreement

All patient information at Providence Medical Clinic is considered confidential. This includes the patient's medical records and any information obtained through a spiritual support session with the patient.

As a paid staff member/volunteer at the Clinic, you are to regard with strictest confidence any information that you learn about a patient and his or her family. You cannot discuss any information that you have learned about a patient with his or her family without the patient's permission. You cannot discuss any information about a patient with other patients in the clinic, outside agencies, your family or personal acquaintances, only staff at Providence Medical Clinic as is necessary for the well-being of the patient.

HIPAA violations cannot be tolerated. Proper release of medical information may be accomplished by following set guidelines through written release of medical information. No information regarding PMCK patients may be discussed outside of clinic. All information is on a need to know basis. If information is not essential for you to do your job, do not access the information.

Providence Medical Clinic will discontinue the services of any volunteer who breeches this agreement.

**Please complete the agreement below:

I agree to keep all patient information at Providence Medical Clinic confidential and will not discuss any information about a patient outside of the Clinic.

Volunteer Name: (Please Print) _____

Volunteer Signature: _____ Date: _____

Witness Signature: _____ Date: _____