



## Viola Startzman Clinic Volunteer Application

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

How do you prefer that we contact you?

Cell  Home  Work  E-mail

Current Job Title and Description of Work \_\_\_\_\_  
\_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Work Address \_\_\_\_\_  
\_\_\_\_\_

In what area(s) are you interested in volunteering? \_\_\_\_\_  
\_\_\_\_\_

What days & hours are you available to serve? \_\_\_\_\_  
\_\_\_\_\_

How did you find out about the Volunteer Program at VSC? \_\_\_\_\_  
\_\_\_\_\_



## **Viola Startzman Clinic Volunteer Application**

### ***Volunteer Experience(s)***

Please describe any current or previous volunteer experiences you have had, including name and address of organization(s), years of services and description of your service: \_\_\_\_\_

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Are you currently, or have you ever been a patient at the VSC? Yes or No

If so, when? \_\_\_\_\_

Please mail, drop off, or e-mail your volunteer application and a copy of your resume to the address below. We will contact you and thank you for your interest in the Viola Startzman Clinic!

**BethAnne Burkhardt, Volunteer Coordinator**

**Viola Startzman Clinic**

**1874 Cleveland Road**

**Wooster, Ohio 44691**

**[bburkhart@startzmanclinic.org](mailto:bburkhart@startzmanclinic.org)**

**Phone (330) 262 2500 Ext. 104**

**Fax (330) 265-8713**

**[www.startzmanclinic.org](http://www.startzmanclinic.org)**

## **Volunteer and Student Rules of Conduct**

### **Overview**

The Viola Startzman Clinic appreciates the hard work that volunteers do to keep the clinic operating. The Board and Executive Director expect volunteers and employees to adhere to high standards of professionalism and dignity. The following rules of conduct work hand-in-hand with those in the employee manual. Interpretation and formulation of policies and procedures fall upon the Board of Trustees and the Executive Director.

### **VSC Mission Statement**

The Viola Startzman Clinic provides medical and dental care, in an atmosphere of dignity and respect, to lower-income residents of Wayne County.

### **VSC Values Statement**

- Our *patients* receive quality health care and participate constructively in that care;
- Our *volunteers* enjoy a positive work environment and satisfaction for time well-spent;
- Our *donors* pay for effective and efficient operations and receive consistent measurement of results; and
- Our *employees* enjoy competitive pay, open communication, and challenging and rewarding work.

### **Rules of Conduct**

1. Volunteer/student must treat patients in a respectful, non-judgemental manner, giving patients undivided attention.
2. Volunteer must never disclose confidential information without proper authorization. (See HIPAA policy).
3. Volunteer should maintain the highest character and integrity in performing assigned duties, i.e., no lying, stealing, falsification.
4. Volunteer should always adhere to policies and procedures.
5. Volunteer should perform duties adequately and properly.
6. Volunteer should act or react in a responsible, courteous, and respectful manner.
7. Volunteer should strive to maintain a good rapport with employees and other volunteers.
8. Volunteer should not engage in any act that may jeopardize the safety of the workplace.

9. Volunteer should refrain from using abusive language that may threaten, intimidate, or offend others.
10. Volunteer may not report to work under the influence of alcohol or illegal drugs.
11. Volunteer is expected to practice good personal hygiene and dress appropriately for the work place.

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Volunteer Signature

Date

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Parental/Guardian Signature for students (under 18)

Date

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Volunteer Coordinator

Date

## **AGREEMENT FOR VOLUNTEER SERVICES**

The Viola Startzman Clinic (VSC) depends on a large, diverse group of volunteers.

**The staff and board are committed to providing volunteers with:**

1. assignment – appropriate orientation and ongoing training;
2. insurance covering accidents that occur onsite; and
3. Medical/malpractice liability insurance for volunteering physicians, nurses, dentists, and dental assistants.

**As a VSC volunteer, I agree that:**

1. The VSC may use my photograph and name as needed for publicity purposes;
2. I will abide by Clinic policies and procedures.
3. I will maintain strict confidentiality of all patient information;
4. I will train new volunteers if I am asked to do so; and
5. I will communicate my concerns/suggestions to the appropriate staff member.

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Volunteer Signature

Date

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Parental/Guardian Signature for students (under 18)

Date

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Volunteer Coordinator

Date

**Emergency Contact**

Please provide the name and phone number of an emergency contact, should we need it while you are performing volunteer work.

Name and relationship

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Phone number

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**SECURITY AND CONFIDENTIALITY AGREEMENT**

As a volunteer or student at the Viola Startzman Clinic (hereinafter “VSC”) and as a condition of my duties, I agree to the following:

- I understand that I am responsible for complying with the HIPAA policies of the VSC.
- I will treat all information received in the course of my duties with the VSC as confidential and privileged information.
- I will not access patient information unless I have a need to know this information in order to perform my volunteer duties.
- I will not disclose information regarding the VSC patients to any person or entity, other than as necessary to perform my job, and as permitted under the VSC HIPAA Policies.
- I will safeguard my computer password and will not post it in a public place or allow anyone, including other employees/volunteers, to use my password to log on to the computer. I will not use anyone else’s password.
- I will log off of the computer as soon as I have finished using it.
- I will not use e-mail to transmit patient information.
- I will not take patient information from the VSC premises without receiving permission from the Executive Director.

***I understand that violation of this agreement could result in disciplinary actions.***

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Name (Print)

Date

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Name (signature)

Witness

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Parent/Guardian Signature (if student under 18)

Date