

<b>For Internal Use Only</b>
Entire Form – Copy for Volunteer Coordinator MM <input type="checkbox"/>
Front Only – Copy for:
Mailing List Coordinator <input type="checkbox"/>
Card Ministry Coordinator <input type="checkbox"/>
Original – Back to Executive Director <input type="checkbox"/>

### A Storehouse For Jesus Volunteer Information – MEDICAL MINISTRIES

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Fax \_\_\_\_\_

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

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone #s \_\_\_\_\_

Are you currently a Storehouse client/patient? Yes \_\_\_ No \_\_\_

Were you ever a Storehouse client/patient? Yes \_\_\_ No \_\_\_

**(Optional, but very helpful)** - To help us keep our mailing list up to date, please provide us with any of the following information regarding your church:

Church Name \_\_\_\_\_

Church Mailing Address (especially if PO Box) \_\_\_\_\_

Church Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ E-mail \_\_\_\_\_

Please indicate your background, experience and qualifications. A reference is requested for all Medical Ministries volunteers.

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Please check the area(s) you are interested in volunteering:

1. **Medical Clinic**  
 Chronic Care Clinic – Tuesday, 8:30 am until finished \_\_\_\_\_  
 Medical Clinic – Thursday, 5:00 pm until finished \_\_\_\_\_  
 Medical Clinic – 1<sup>st</sup> & 3<sup>rd</sup> Monday, 5:00 pm until finished \_\_\_\_\_
2. **Dental Clinic** – Thursday evenings or Friday mornings (dates and times to be determined monthly) \_\_\_\_\_
3. **Pharmacy and Medication Assistance Program**  
 Monday, 9:00 am until finished \_\_\_\_\_  
 Wednesday, 9:00 am until finished \_\_\_\_\_  
 1<sup>st</sup> & 3<sup>rd</sup> Monday, 5:00 pm until finished \_\_\_\_\_  
 Thursday, 5:00 pm until finished \_\_\_\_\_
4. **Eye Clinic** (days and times to be determined monthly) \_\_\_\_\_

**I am interested in volunteering in the following position(s):**

**MEDICAL CLINIC:**

- Physician \_\_\_\_\_
- Physician's Assistant \_\_\_\_\_
- Nurse Practitioner \_\_\_\_\_
- Lab Tech \_\_\_\_\_
- Nurse \_\_\_\_\_
- Certified Nursing Assistants \_\_\_\_\_
- Receptionist \_\_\_\_\_
- Medical Secretary \_\_\_\_\_
- Appointment Clerk \_\_\_\_\_
- Eligibility Interviewer \_\_\_\_\_
- File Clerk \_\_\_\_\_
- Interpreter \_\_\_\_\_
- Volunteer Meals Coordinator \_\_\_\_\_
- Provider and/or Server of meals for Medical Clinic Volunteers \_\_\_\_\_

**DENTAL CLINIC:**

- Dentist \_\_\_\_\_
- Dental Assistant (*there is an urgent need for volunteers in this position*) \_\_\_\_\_
- Hygienist \_\_\_\_\_
- Appointment Clerk \_\_\_\_\_
- Receptionist \_\_\_\_\_
- Eligibility Interviewer \_\_\_\_\_
- Interpreter \_\_\_\_\_
- Volunteer Meals Coordinator \_\_\_\_\_
- Provider and/or Server of meals for Dental Clinic Volunteers \_\_\_\_\_

**PHARMACY VOLUNTEER POSITIONS**

- Pharmacist (*there is an urgent need for volunteers in this position*) \_\_\_\_\_
- Pharmacy Tech \_\_\_\_\_
- Samples Puncher \_\_\_\_\_
- Receptionist \_\_\_\_\_
- MAP Interviewer \_\_\_\_\_
- MAP File Clerk \_\_\_\_\_

Other \_\_\_\_\_

**Comments**

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Date of volunteer orientation \_\_\_\_\_  
Date volunteer began working \_\_\_\_\_

**MEDICAL CLINICS VOLUNTEER STAFF POSITIONS**

Clinic Director  
Thursday Clinic Coordinator  
Thursday Assistant Clinic Coordinator  
Tuesday Chronic Care Clinic Coordinator  
Tuesday Assistant Chronic Care Clinic Coordinator  
Lab Tech Coordinator  
Clinic Volunteers Coordinator  
Spanish Interpreters Coordinator

**PHARMACY VOLUNTEER STAFF POSITIONS**

Pharmacy Director  
Medication Assistance Program (MAP) Coordinator

**DENTAL CLINIC VOLUNTEER STAFF POSITIONS**

Dental Clinic Director  
Dental Volunteer Coordinator

**A Storehouse For Jesus**  
**Agreement Form for All Volunteers, Students, Community Service Workers, Etc.**

\_\_\_\_\_  
Volunteer Name

\_\_\_\_\_  
Parent Name  
(if volunteer is less than 18 years of age)

\_\_\_\_\_  
Witness Name

**Liability Release**

I understand that I am responsible for my safety while on the premises of A Storehouse For Jesus, while traveling in the Storehouse vehicles to the Food Bank or picking up at other locations, and traveling to and from A Storehouse For Jesus.

I hereby release and hold harmless A Storehouse For Jesus, its directors, officers, volunteers and any independent contractors from and against any and all actions, losses or claims of any nature, which may arise as a result of an accident or injury suffered by a family member or myself while volunteering or being transported to or from A Storehouse For Jesus.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (if less than 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Volunteer Confidentiality Agreement**

As a volunteer of A Storehouse For Jesus I agree to keep all information on clients and patients in the strictest confidence. I agree not to reveal the identity of any client or patient I may encounter at the Storehouse. I agree not to discuss any client's or patient's situation outside the Storehouse.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (if less than 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**Medical Release and Emergency Consent Form**

In the event of illness or injury requiring immediate medical attention, representatives of A Storehouse For Jesus are hereby authorized to take whatever action is deemed by them to be appropriate under the circumstances to provide medical treatment for the individual named below, including, but not limited to the following: administer first aid, obtain services of a physician, transportation to the nearest available hospital, admit to a hospital, consent to medical treatment or surgery. I understand that I will be responsible for any expenses incurred on my behalf in connection with such treatment.

\_\_\_\_\_  
Volunteer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (if less than 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date