Providence
Medical Clinic of Kingsport

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

VOLUNTEER APPLICATION

Patient Care/Nurse 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.)

Patient care staff must be licensed/certified in the state of Tennessee. All PMCK professional medical staff must pass license verification through TN Health Related Boards. You must submit a copy of your license or certification with this application.

REFERENCE:
Please provide the name of a medical professional who we may contact for a peer reference regarding your professional competency and ethical character.

Reference Name: _____

Reference Email or Phone: _____

WHEN ARE YOU INTERESTED IN WORKING?

Providence Medical Clinic will be Monday, Tuesday, Wednesday and Friday 9:00 a.m.-1:00 p.m.

Thursday Evening Clinic doors will open from 4:00 p.m. until 5:30 p.m.

How often would you like to volunteer at the clinic?

___ Once a week ___ Once a month

___ Once a quarter ___ PRN (as needed)

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 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 has been contacted with initial schedule. __ Y or __ N If yes, when_____
3. Applicant has signed the PMCK Confidentiality Agreement. __ Y or __ N

10/06/2020

Revised 11/30/2021 PWallace

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.

HIPPA violations can not 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: _____