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**Helping Hands Free Medical Clinic**

230 South Main Street 1328 North Main Street

**Mullins,** South Carolina 29574 **Marion,** South Carolina 29571

Phone (843) 464 – 8750 Phone (843) 423 – 5212

Fax (843) 464 – 0938 Fax (843) 423 – 5593

**MEDICAL CLEARANCE FOR HHFMC VOLUNTEERS**

TO:

(Name of primary care provider)

FROM: Erin Floyd, PA-C

Clinic Director

SUBJECT: Volunteer

Helping Hands Free Medical Clinic

DATE:

is a volunteer with HHFMC. In order to comply with regulatory requirements, we need you to complete the following statement. Please mail or fax this statement to me. The address and fax number is listed above. Thank you for your assistance in this matter.

was seen on for an office visit and is:

□ Medically qualified to perform the duties of a volunteer.

□ Not medically qualified to perform the duties of a volunteer.

Physician/PA/NP Signature

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**Volunteer Application**

Last Name First Name M. I.

Home Address

City State Zip Code DOB

Home Phone Cell Work

Place of Employment

Job title/duties

*Please indicate the type of volunteer services you can offer:*

□ Physician □ Pharmacist □ Physician Assistant □ Nurse Practitioner □ RN □ LPN

□ Receptionist □ Computer Operator □ Pharm Tech □ Screener □ Other \_\_ \_\_\_\_\_\_\_\_\_\_

*Additional training and/or skills which you feel will enhance your services:*

Days available for volunteering: □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday

Have you been vaccinated for Hepatitis B? □ Yes □ No Date Given

Have you had a TB screening test in the past year? □ Yes □ No Date Given

*Please list two references (personal and professional) that can verify your experience.*

Name Name

Address Address

Phone Phone

Emergency Contact Telephone

Volunteer Signature Date

** Helping Hands Free Medical Clinic **

**Confidentiality Policy**

Policy:

Health Insurance Portability and Accountability Act (HIPAA)/Maintaining patient confidentiality and dignity is of utmost importance to the HHFMC. Client records will be kept on all individuals requiring our services. The staff and volunteers will consider all information gathered about a client as private and confidential. All records are the property of HHFMC.

Confidentiality will be kept by the following guidelines:

* No information will be made public without the written or direct oral consent of the patient.
* General information may be shared with other professionals (social worker, attorney, pastor, etc.) who are working on behalf of the patient when the patient has consented to the release of this information.
* No one other than a staff member or volunteer trained for counseling or interviewing can solicit information from the patient on the premises of HHFMC. Violation of these guidelines will result in a “request to leave” by the medical director or clinical coordinator.
* Violation of confidentiality will be considered sufficient reason to terminate employment or volunteer activities.

*I have read and understand HHFMC’s policy on confidentiality.*

Volunteer Signature Date

**FOR HELPING HANDS FREE MEDICAL CLINIC USE ONLY**

Licensed as: Physician Pharmacist Physician Assistant Nurse Practitioner

RN LPN Social Worker BOD Expiration Date

Orientation Date Provided by

** Helping Hands Free Medical Clinic **

**Hazard Communication Standard**

“Right to Know”

Policy:

Helping Hands Free Medical Clinic is committed to providing a safe workplace for all volunteers. This facility is committed to complying with the OSHA Hazard Communication Standard (Right to Know). The OSHA Standard requires that every volunteer:

* Has access to a written hazard communication program that explains how volunteers are educated regarding hazardous materials and their appropriate labeling in the work environment.
* Be informed regarding the Material Safety Data Sheet (MSDS) for all required products. These documents must be available for easy reference.
* Be trained to identify and handle hazardous materials.
* Be aware of any hazards in their work area.

*I have read and understand HHFMC’s Hazard Communication Standard policy.*

Volunteer Signature Date

** Helping Hands Free Medical Clinic **

**Electrical Equipment Safety**

Purpose**:** To provide guidelines for lock-out/tag-out of electrical/mechanical equipment.

Policy: It is the policy of Helping Hands Free Medical Clinic that all equipment capable of accepting lock-out devices will be locked-out and tagged whenever it is undergoing servicing or maintenance.

If there is any equipment on the premises that will not accept lock-out devices, tag-out procedures and devices will be used when servicing that equipment.

Procedure:

1. All equipment will be locked-out or tagged-out to protect against accidental or inadvertent operations that could cause injury to personnel.
2. No attempt shall be made to operate any switch, valve, or other energy-isolating device that is locked or tagged.
3. Sequence of Lock-out or Tag-out System:
   1. Notify all affected employees that a lock-out or tag-out system is going to be utilized on a piece of equipment, as well as the reason lock-out/tag-out is being performed. The technician performing the lock-out/tag-out must know the type and magnitude of the electricity the equipment uses and understand the hazards of electricity.
   2. If the equipment is operating, the proper shut down procedure must be followed (press stop button, open toggle switch, etc.).
   3. The appropriate switches, valves, or other energy-isolating devices must be installed so that the equipment is isolated from its energy source. Stored energy (such as that in springs, parts of the equipment that are elevated and could drop, rotating flywheels, capacitors, hydraulic systems, air, gas, steam, or water pressure, etc.) must be dissipated or restrained. This can be accomplished by methods such as repositioning, blocking, bleeding down, grounding, etc.
   4. The energy isolating devices shall be locked-out/tagged-out with the appropriate locks and/or tags.
4. Restoring Machines or Equipment to Normal Production Operations:
   1. After maintenance has been performed and prior to resuming normal production operations, a secure area must be established.
   2. Once the area is secured, all lock-out/tag-out devices may then be activated to restore energy to the equipment.
5. Procedure Involving More Than One Person:
   1. In the preceding steps, if more than one person is required to lock-out or tag-out equipment, each person shall place his own lock-out/tag-out device on that equipment.
   2. When an energy-isolating device cannot accept multiple locks or tags, a multiple lock-out/tag-out device (such as a multi-holed hasp) may be used. As an alternative, a single lock may be used with the key placed in a lock-out box or cabinet, allowing the use of multiple locks to secure the cabinet. Each employee will then use his own lock to secure the cabinet.

*I have read and understand HHFMC’s Electrical Equipment Safety purpose, policy, and procedures.*

Volunteer Signature Date

** Helping Hands Free Medical Clinic **

**Blood Born Exposure**

Policy:

The staff at Helping Hands Free Medical Clinic does not presently draw blood samples for testing, however, this may be subject to change. Finger stick blood sugars and injections (influenza vaccine, insulin, etc.) are the only means of blood exposure currently. Sharps (needles and lancets) are disposed of in red bio containers.

Spills will be cleaned as soon as possible. When exposure to blood or body fluids is anticipated, protective equipment will be used (ie. gloves, goggles, face shields, gowns).

Contaminated waste will be placed in red biohazard bags, secured, and placed in the covered waste containers marked with the biohazard symbol located in the soiled utility room. All waste will be transported from the clinic by the housekeeping staff. Only items saturated in blood or body fluids should be placed in red biohazard bags. Bio WASTE Company will pick up waste for disposal.

*I have read and understand HHFMC’s policy on blood born exposures.*

Volunteer Signature Date

**Infectious Disease Checklist**

□ Results of PPD negative. DATE GIVEN:

□ If previous positive PPD, chest x-ray required.

□ Flu shot recommended. DATE GIVEN:

□ Volunteer refuses or is allergic to flu vaccine.

Volunteer Signature Date

Staff Signature Date

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**ACKNOWLEDGEMENT OF RECEIPT OF POLICY AND PROCEDURES**

*I acknowledge that I have received, read, and understand the policy and procedures of Helping Hands Free Medical Clinic.*

Volunteer Signature Date

Print Name

**Thank you for your interest in volunteering at Helping Hands Free Medical Clinic!**

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