Servolution Health Services, Inc.
181 Powell Valley School Lane
Speedwell, Tennessee 37870
423-419-5070
www.servolutionhealthservices.org

VOLUNTEER APPLICATION

Today's Date_____

Full Name: _____ Date of Birth: _____
(First) (Middle/Maiden) (Last)

Local address, city and zip code: _____

Social Security Number (for background check purposes): _____

Phone numbers:

Home: _____ Email address: _____

Work: _____ Fax: _____

Cell: _____ Pager: _____

Employer: _____ Title: _____

School: _____ _ Anticipated grad date: _____

Concentration / Major / Program of study: _____

**** If you are a medical professional, please fill out appropriate addendums following this application.**

Why are you interested in volunteering at Servolution Health Services (SHS)?

How do you see your service supporting SHS's mission statement?

Please share a little bit about yourself (family, hobbies, personal interests, etc):

List any special skills or talents you have to offer (languages spoken, art, music, photography, etc):

What is your faith identity? (ex: Christian, Jewish, Muslim, No Faith): _____

What church / house of worship do you attend? _____

List any community groups or professional organizations you are a part of:

How did you hear about Servolution Health Services? Please be specific:

Are there any work conditions or situations that you must avoid? If yes, please explain.

Have you ever been convicted of a felony? If yes, please explain.

Are there any other past criminal incidents SHS should know about?

In case of emergency, who is your primary & secondary contact?

Primary Contact Name : _____ Relationship to you: _____

Phone number(s) _____

Secondary Contact Name: _____ Relationship to you: _____

Phone number(s) _____

Are there any health concerns we should know about (allergies, medications, other conditions)?

List two references – one personal, one professional:

Name: _____ Phone: _____

Name: _____ Phone: _____

I give Servolution Health Services, Inc. permission to conduct a nation-wide criminal background check, using my date of birth and social security number. _____initial

I give Servolution Health Services, Inc. permission to photograph me and use my physical likeness in brochures, photo exhibits, or websites, for any purpose, whether for ministry, education, public relations, or fundraising. _____initial

Confidentiality Statement

As a volunteer at Servolution Health Services, Inc. I am aware of patients' right to confidentiality. I realize that any information I obtain regarding patients is to remain confidential. All patient information is considered private protected health information and no person should look at this information unless it is required to complete the task that they are assigned. If a person does see private information, that information cannot be shared and is to be kept confidential unless not sharing it would be detrimental to the patient's or another person's health. I understand and agree to abide by this statement of confidentiality and attest to the accuracy of the information I have included on this form.

Printed Name: _____Signature: _____

Medical Professional Addendum

(for clinical volunteers with licensure or certification)

Name: _____ Date: _____

Profession / Title: _____ Area of specialty: _____

License #: _____ Certification #: _____

Date of last Credentialing_____Date of last Privileging_____

Person and Organization Conducting Credentialing/Privileging_____

Hospitals at which you have privileges: _____

How you will serve at SHS:

- ☐ Physician
- ☐ Nurse
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physician's Assistant
- ☐ Nurse Practitioner
- ☐ Dentist
- ☐ Dental Hygienist
- ☐ Chiropractor
- ☐ Ophthalmologist
- ☐ Optometrist
- ☐ Other_____

Is there a particular patient population you most enjoy working with or have the most experience providing care for?

Please describe any legal practice limitations or supervising provider arrangements, if applicable:

Please answer the following questions and explain affirmative responses on back or on additional sheet.

Have you had your license to practice medicine suspended, revoked, or restricted?

☐ Yes ☐ No

Have you had disciplinary measures taken against you by the Board of Nursing/Board of Medical Examiners?

☐ Yes ☐ No

Have you had your clinical privileges at any health care facility deemed suspended, restricted, or revoked?

☐ Yes ☐ No

Have you ever had disciplinary measures taken against you at a health care facility?

☐ Yes ☐ No

Has your DEA ever been restricted, suspended, or revoked?

☐ Yes ☐ No

Have you experienced any impairment due to chemical dependence or substance abuse?

☐ Yes ☐ No