SHEPHERD'S HAND

A place of HOPE that BUILDS COMMUNITY and CHANGES LIVES

Dental Clinic Volunteer Application

A: GENERAL INFORMATION

Name: _____ Date of Birth: _____
Physical Address: _____ City/State/Zip Code: _____
Mailing Address: _____ City/State/Zip Code: _____
Phone No.: _____ Cell Phone No.: _____
E-mail address: _____
Employer: _____ Address: _____
Job Title: _____ Years worked: _____ Work Phone No.: _____
Job Duties: _____

B: AREA OF INTEREST

DENTAL CLINIC: Most positions require a once a month commitment. The clinic is open once a week on Monday evening from 5:45 to 9:00 p.m. (approximately). Some positions require you to stay until the end of clinic while others do not.

- ☐ Dentist
- ☐ Dental hygienist
- ☐ Dental assistant

Do you have any physical or mental health impairments, including alcohol or drug usage that would affect your ability in terms of skill, attitude or judgment to perform your volunteer duties?

- ☐ Yes
- ☐ No

All licensed volunteers continue with **Section C**. SHFC is a Federal Tort Claims Act deemed free clinic. All licensed volunteers must be credentialed in order to have malpractice coverage while at SHFC. All non-licensed volunteers proceed to **Section D**.

C: CREDENTIALING INFORMATION

ALL LICENSED PROFESSIONALS:

School Attended: _____
Address: _____ Date of Graduation: _____
Montana State Board of Licensure: _____ License No.: _____
Issue Date: _____ Expiration Date: _____

DENTISTS:

Internship Location: _____
Type of Internship: _____ Dates of Internship: _____
Residency Location: _____
Type of Residency: _____ Dates of Residency: _____
Fellowship Location: _____
Type of Fellowship: _____ Dates of Fellowship: _____

Do you have malpractice insurance?

- ☐ Yes
- ☐ No

Have you ever had any disciplinary action against your professional license, or has your license ever been revoked or suspended, restricted, or modified in any state?

- ☐ Yes
- ☐ No

If yes please state the reason for the action and include date and state of action:

_____

_____

Have you had any malpractice claims against you in the past 10 years?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

_____

Have your privileges at any hospital, clinic, or health care institution ever not been renewed, **or** have they ever been suspended, diminished, or revoked?

- ☐ Yes
- ☐ No

In order to process your application, copies of the following documents must be submitted with your application:

- ☐ Driver license or other government issued photo ID
- ☐ Montana State License
- ☐ Signed "Release of Information for Credentialing Purposes" document
- ☐ DEA certificate, if applicable
- ☐ Malpractice insurance certificate, if applicable
- ☐ Any additional pertinent certifications or specialty training

NOTE: SHFC WILL VERIFY YOUR STATE LICENSURE THROUGH THE MONTANA DEPARTMENT OF LABOR & INDUSTRY eSERVICES WEBSITE AND CONDUCT A SEARCH THROUGH THE NATIONAL PRACTITIONERS DATABASE

D: VACCINATION AND TRAINING COMPLIANCE

- ☐ I have had a full (3 shot) hepatitis B vaccination series.
- ☐ I have not had a full (3 shot) hepatitis B vaccination series. I understand that due to my occupational exposure to blood or other potentially infectious material I may be at risk of acquiring hepatitis B virus (HBV) infection.
- ☐ I have received Occupational Safety and Health Administration (OSHA) training and am up-to-date with standards.

E: SHEPHERD'S HAND FREE CLINIC POLICIES

Please review the following clinic policies. It is expected that each volunteer adhere to these standards.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) STANDARDS:

Confidentiality means protecting a patient's privacy and sharing clinic business only with those who have a need to know. The "need to know" is defined as the need to have information to perform your job as a volunteer. Confidential patient information includes, but is not limited to: patient's presence, medical, financial, quality assurance/quality

improvement/performance improvement, and risk management date. By signing below you are agreeing to maintain absolute confidentiality of all Shepherd's Hand Free Clinic information. This expectation pertains to patient as well as family member (including children, parents, spouses, siblings) and business arrangement information. Any breach of confidentiality must be reported to the clinic director to determine appropriate remedy.

I understand that this means that I will not discuss confidential patient information with others or access this information, including electronic, unless it is required in the performance of my duties and is the minimum necessary.

DRESS CODE:
All dentists, dental coordinators, dental hygienists, and dental assistants are expected to dress as they do for their professional clinic. The personal protective equipment (PPE) that will be provided by SHFC is eye protection, gloves, and facemasks. No sandals or open toe-shoes.

Dental screeners do not have a "dress code" in the sense of mandated attire. We do ask that you dress neat, clean, and with modesty. One way to judge the appropriateness of your attire is to ask yourself if you can bend, kneel, and move around with ease and modesty.

All volunteers are expected to wear their nametag.

DEPENDABILITY:
The clinic schedule is developed quarterly. Volunteers have an opportunity to make requests during the development process. In general, volunteers are scheduled on a four to five week rotation. Once on the schedule, volunteers are expected to make their own trades if a scheduling conflict arises.

Once you become a clinic volunteer, we depend on you to be here! We are left short-handed when you do not come. If you are unable to work, please make every effort to find another volunteer working in your same area to replace you and notify the volunteer coordinator so that the schedule can be updated. If you are unable to find a replacement, please contact the volunteer coordinator so the appropriate staffing can be secured.

ATTITUDE:
Treat patients with dignity, respect, and compassion. Make every attempt to be patient and pleasant, even when the patient is not. Also important is the ability to be flexible when the unexpected happens and handling change with a good attitude.

I attest to the correctness and completeness of the information furnished. The information I have provided may be verified, if necessary, by contacting persons or organizations named in this application, or by contacting any person or organization that may have information concerning me, or by conducting a criminal background check. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to support Shepherd's Hand Free Clinic's (SHFC) mission, values, and policies and procedures. In signing this agreement I recognize that I am putting myself under the authority of the SHFC Board of Directors and leadership of the clinic.

Signature: _____ Date: _____

Please e-mail this application to jessica@shepherdshand.com or mail to 5150 River Lakes Parkway, Whitefish, MT 59937. You will be contacted by the director of volunteers upon receipt of your application.

All information supplied is held confidentially and shared only with appropriate SHFC staff