DOAR & Affiliates
Volunteer Application Form

Instructions to Applicant:

1) Determine Location/Facility where you would like to volunteer. See www.doarpt.com/locations
2) Complete this form.
3) Sign and attach Exhibit A to this application
4) Complete HIPAA training. Attach documentation of training completion to this request.
5) Sign and attach Exhibit B to this application
6) Submit request with attachments to the Location Manager for review/approval.

Contact Information

Participant Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

If a Student, School: _____

Level of Student: _____ Expected Graduation Date: _____

If a Minor, Parent or Legal Guardian Name: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____

Medical Information
Please check the boxes that apply:

- ☐ To the best of my knowledge, I have no long-term medical or psychological condition, or any other reason that may prevent me from safely working as a volunteer. - **OR -**
- ☐ I am under a doctor's or therapist's care for a long-term medical or psychological condition, and have a letter from him/her stating that I can safely and reliably work as a volunteer.

- ☐ I have previously had a positive Tuberculosis (TB) skin test or screening but have a negative chest x-ray in the past 12 months (attach report or letter from physician as documentation). - **OR -**
- ☐ I have previously had a negative Tuberculosis (TB) skin test or screening TB) skin test or screening in the past 12 months (attach report or letter from physician as documentation). - **OR -**
- ☐ I acknowledge a Tuberculosis (TB) skin test or screening is required for all volunteers. I will obtain a TB skin test or screening and submit documentation from physician prior to beginning volunteering.

Criminal Background

Have you ever been convicted or plead guilty in court (even if you did not have a trial) for anything other than a minor traffic violation? (circle one) Yes / No

If yes, please explain: _____

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References
Names of at least two references not related to you and whom you have known at least one year. Students should include three references - one must be a school contact.

Name	Phone	Relationship
1.		
2.		
3.		

Volunteer Requests

Location/Facility Requested: _____

Start Date Requested: _____ End Date Requested: _____

Specific Hours/Days Requested: _____

Note: We request that volunteers commit to at least 4 hours per week for a 3 month period.

Purpose of Volunteering
Please note: If you are interested in volunteering due to a court ordered requirement, we will be unable to help you at this time.

_____
_____
_____
_____
_____
_____

TO THE APPLICANT: Your signature indicates that the facts contained in this application are true and complete to the best of your knowledge. If employed as volunteer, falsified statements on this application shall be grounds for dismissal. You authorize approval to check references. The organization is not obligated to provide a placement, nor are you obligated to accept the position offered. Signing up as a volunteer in no way guarantees a paid position.

Applicant's Signature: _____ Date: _____

PARENTAL CONSENT: If you are a minor under the age of 18, a parent or legal guardian must sign. Note to the parent/legal guardian(s): Your signature indicates that your son/daughter is in good health and has your permission to volunteer at DOAR & Affiliates. It authorizes us to perform the necessary tests to obtain medical information required for this application. Your signature also authorizes emergency medical care while your son/daughter is on duty.

Parent/Guardian's Signature: _____ Date: _____

FOR OFFICE USE ONLY

Application Received By: _____ Date: _____

References Checked By: _____ Date: _____

Notes: _____
_____
_____

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EXHIBIT A

RESPONSIBILITY AND CONFIDENTIALITY STATEMENT

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of _____ ("Facility"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the observation at Facility unless such injury of loss arises solely out of Facility's gross negligence or willful misconduct.

My sponsoring facility, academic facility, employer or I have personally provided evidence of my professional and/or general liability insurance to the Facility department authorizing my observation activity. If I do not provide evidence of insurance, I am personally liable for all injury, illnesses, or damages to myself or others related to my participation in this event. I hereby release, hold harmless, acquit, and forever discharge the Facility, Center for Pediatric Therapies, Inc., All Care Home Health, Inc., Accelerated Care, Inc., Martinsville Physical Therapy & Industrial Rehabilitation, Inc., Danville Orthopedic & Athletic Rehabilitation, Inc., and each of these entities, their agents, servants, successors, or assigns, for any and all actions, causes of action, claims, demands, damages, costs, expenses, any present or future healthcare charges related or unrelated to medical treatment and compensation, arising out of, or related in any way to my observation in patient care areas in this Facility or its associated entities.

In addition, the undersigned agrees to:

1. Abide by the Policies and Procedures of the Facility;

2. Comply will all applicable federal, state and local statutes and regulations in connection with the observation;

3. Obtain prior written approval from the Facility before publishing any materials relating to the observation.

The undersigned hereby acknowledges her/her responsibility under applicable Federal law to keep confidential any information regarding Facility patients, as well as all confidential information of Facility. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Facility, except as required by law or as authorized by Facility.

_____

Participant Name Date

_____

Participant Signature Date

_____

Parent or Guardian Name if Participant is a Minor Date

_____

Parent or Guardian Signature if Participant is a Minor Date

_____

Witness Name Date

_____

Witness Signature Date

_____

Location Manager Signature Date

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EXHIBIT B

CONFIDENTIALITY STATEMENT

The Health Insurance Portability and Accountability Act Privacy Regulations

As of April 14, 2003, the federal Health Insurance Portability and Accountability Act (HIPAA) provides patient protections in connection with the use and disclosure of their health information, in addition to those protections that already exist under state law. _____ ("Facility"), are committed to protecting the privacy and security of our patients" health information.

By signing this statement, I acknowledge my responsibility under state and federal law and agree not to disclose or share with others, and keep confidential, any information regarding Facility patients and proprietary information of Facility. I agree that if I have access to patient information, not to reveal to any patient specific information, including that this person is a patient at the Facility and any information I may learn about the circumstances of the patient's care, and further agree not to reveal to anyone else any confidential information of this Facility. I agree to comply with any patient information privacy and security policies and procedures of the Facility. I further acknowledge that the importance of patient privacy, security and confidentiality has also been verbally discussed with me, and that I had an opportunity to ask questions regarding the Facility's privacy and security policies, procedures and practices.

I have read and understand the terms of this statement and agree to abide by these terms. Should I choose to reveal confidential patient information to anyone. I acknowledge that the Facility provided me with the applicable information and training in order to prevent any and all violations of the laws regarding patient privacy, security and confidentiality.

_____

Participant Name Date

_____

Participant Signature Date

_____

Parent or Guardian Name if Participant is a Minor Date

_____

Parent or Guardian Signature if Participant is a Minor Date

_____

Witness Name Date

_____

Witness Signature Date

_____

Location Manager Signature Date