Healing Hands Community Clinic

PO Box 2143

Blairsville, GA 30512

Phone# 706-994-6768

Volunteer Information Sheet

Name:____

Address:____

Phone Number (Home)________________________**Cell#**_________________

Email Address____

Areas of interest: Hobbies/skills____

Do you hold a professional license of any type?__________________________

Have you ever been convicted of a felony?_______________________________

Have you ever been convicted of a crime against a child?___________________

Have you ever had your professional license suspended or revoked?_________

Will you be willing, if necessary, to agree to a background check?_________

Will you be willing to sign a confidentiality agreement?______________

We look forward to you helping complete our vision in creating this wonderful clinic for our community.

Sandra Sharrock sandysharrock@windstream.net

Volunteer Coordinator- Healing Hands Community Clinic

Clinic volunteers will respect clinic and patients confidentiality. Confidentiality information includes all medical, dental, and pharmacy services regarding patients. Patient's names, addresses, medical diagnosis, and all personal information are confidential and should not be shared with anyone. Volunteers should always use caution when speaking with a patient so that any personal information cannot be heard by others. All information regarding HHCC operations is confidential and should not be shared with others.

I will not repeat or disclose any patient information or administrative information that I observe, hear or read while volunteering at HHCC.

Signed _______________________________________ **Date**______________________