SBNC
SANTA BARBARA NEIGHBORHOOD CLINICS
Your Health Home

Volunteer Application Form

Thank you for your interest in volunteering with our organization. The process is as follows:

1. Complete this application thoroughly (include a copy of your immunization records).
2. Submit your application to volunteer@sbclinics.org or send directly to our administrative office at 414 East Cota St., 1st Floor, Santa Barbara, CA 93101. Direct your application to Human Resources (example: Attn: HR, Human Resource Department).
3. Your application will be reviewed during the application cycle and if selected, we will contact you to schedule an interview with one of our clinic managers.
4. If you pass your interview, the next step will be for you to undergo a background check, complete and pass three training modules, as well as attend a mandatory orientation. Orientation is discussed during interview. (Failure to complete and/or not pass these assignments will result as disqualification, resulting in not moving forward with your volunteer application).
5. Once you complete step four, the Human Resource Department will inform both you and the Clinic Manager that you are ready to start the current volunteer cycle.

Please Note: Because of the high volume of applications that are submitted during the cycle period, it is not a guarantee that every applicant will receive a telephone call for an interview.

Where would you prefer to volunteer? (Please check all that apply.)

☐ Eastside ☐ Dental ☐ Isla Vista ☐ Westside ☐ Goleta ☐ Administration
☐ Goleta Neighborhood Dental

_____ Directly with patients _____ In support areas

☐ Health Promotion Services ☐ Dental ☐ Medical ☐ Extern ☐ Patient Portal Enroller

Please print legibly, and complete all fields in blue or black ink.

Last Name: _____ First Name:_____ D.O.B: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Telephone #: _____ Alternate Telephone #: _____

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Email: _____

Name of person to contact in case of an emergency:

Full Name: _____ Relationship: _____

Telephone Number: Day: _____ Evening: _____

If you need volunteer hours for school/college credit, how many hours?

_____ hours per ☐ Week ☐ Month ☐ Quarter ☐ Semester

Date you can begin to volunteer: _____

How did you hear about volunteering at SBNC? (Check one that applies)

_____ SBNC Website _____ SBNC Employee ____ Flyer/Brochure ____School/College

_____Other (if you selected other, please explain below)

_____

_____

Please list the name of the school/vocational program/college/university that is requiring volunteer hours.

Name: _____

Contact Name: _____

Information about your volunteer interest.
Please tell us why you are interested in volunteering at Santa Barbara Neighborhood Clinics.

_____

_____

_____

_____

Information about your interest/skills/experience and availability.

Rank your Spanish speaking skills. ☐ Beginning ☐ Intermediate ☐ Advanced

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What is the length of commitment you are able to make? (For example, 5 hours per week for 12 months. This is where you can briefly explain availability under a year.)

_____

_____

Please list the experience and/or skills you possess that would be useful in volunteering at SBNC.

_____

_____

_____

Please list your current and/or previous volunteer roles with other organizations.

_____

_____

_____

Please fill in the most appropriate days and blocks of time you would be available to volunteer:
(For example, Mondays from 9am – 1pm, Thursdays from 2pm – 6pm)

Days:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Time Period:						

Are you available/interested in supporting SBNC at special events?

____ No ____ Yes

Are you available/interested in assisting with special projects such as mailing or office work?

____ No ____ Yes

Signature of Volunteer: _____

Date: _____

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Confidentiality Agreement for Volunteers

I recognize and acknowledge that, as a result of my continued association with the Santa Barbara Neighborhood Clinics (SBNC), I may receive, develop, become acquainted with and otherwise have access to confidential and privileged information of SBNC, including HIPAA protected patient information, quality improvement information, financial data, personnel information and other similar confidential matters (hereinafter collectively referred to as "Confidential Information").

I acknowledge that such confidential information is a valuable and unique asset of SBNC as well as, in many cases, legally protected. I promise that I will not, either during or after my association with SBNC, use or disclose any such confidential information to any unauthorized person or entity. I further acknowledge that I will immediately report any misuse of such confidential information that I may encounter by another person or employee to the Chief Executive Officer (CEO).

Upon termination of my association with SBNC or upon request of the CEO or Board of Directors, I agree to return promptly to SBNC all confidential information in my possession or control and that any personal knowledge of confidential information will not be divulged under any circumstances.

I understand that it is the privilege of SBNC to exercise all available remedies under the law in the event of any unauthorized use of confidential information and that I will be subject to disciplinary action, up to and including termination, in the event of a breach of this confidentiality agreement.

Signature of Volunteer: _____

Date: _____

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Drug Free Volunteer Policy

Santa Barbara Neighborhood Clinics maintains a drug-free workplace and volunteer environment in accordance with the provisions of the California Drug-Free Workplace Act of 1990.

Santa Barbara Neighborhood Clinics strictly prohibit the unlawful manufacture, distribution, dispensation, possession, or use of any alcohol, illegal drugs, or controlled substance in the volunteer environment.

Please Note: Use or possession of marijuana is illegal under federal law. SBNC considers marijuana to be an illegal drug. A physician's recommendation for marijuana use does not change marijuana's status as an illegal drug for the purposes of this policy.

VIOLATION OF POLICY:

The Santa Barbara Neighborhood Clinics has "zero tolerance" policy that no volunteer or employee will be allowed to work who possesses, distributes, sells, offers to sell, or reports to any of our clinics under the influence of any drug, controlled substance or alcohol, or who misuses prescription drugs.

Any violation of the above policy by Santa Barbara Neighborhood Clinics Volunteers will result in immediate dismissal of the Volunteer Program. SBNC may also bring the matter to the attention of the appropriate law enforcement authorities.

I have read and understand SBNC's Drug Free Workplace Policy.

Signature of Volunteer: _____

Date: _____

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Child Abuse Reporting

In compliance with Penal Code Section 11166.5, please read the following information. Please sign to acknowledge your understanding of the legal requirements.

"Section 11166 of the Penal Code requires any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspected instance of child abuse to a child protective agency immediately or as soon as practically possibly by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident."

"Child care custodian' includes teachers, administrative officers, supervisors of child welfare and attendance, or certified pupil personnel employees of any public or private school, administrators of public or private day camp; licensed day care workers; administrators of community care facilities licensed to care for children; Head Start teachers; licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to foster parents, group home personnel, and personnel of residential care facilities; and social workers or probation officers.

"Medical practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, or any other person who is licensed under Division 2 (*commencing with Section 500*) of the Business and Professions Code.

"Nonmedical practitioner" includes state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage, family or child counselors; and religious practitioners who diagnose, examine or treat children.

"The signed statements shall be retained by the employer. The cost of printing, distribution and filing of these statements shall be borne by the employer."

Signature of Volunteer: _____

Date: _____

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Adult Abuse Reporting

California Welfare and Institutions Codes Section 15632 requires Santa Barbara Neighborhood Clinics to provide all "dependent adult care custodians" and "health practitioners" who are employees after January 1, 1986 (*both continuing and new employees*), with the following statement. The legal definition of "care custodian" includes all employees of a hospital. California law requires that this statement be signed by the employee as a prerequisite to employment and be retained by the Santa Barbara Neighborhood Clinics.

Section 15630 of the Welfare and Institutions Code requires any care custodian, health practitioner, or employee of an adult protective services agency or local law enforcement agency who has knowledge of, or observes a dependent adult in his or her professional capacity, or within the scope of his or her employment, who he or she knows has been victim of physical abuse, or who has injuries under circumstances which are consistent with abuse, where the dependent adult's statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred, to report the known or suspected instance of physical abuse to an adult protective services agency or a local law enforcement agency immediately, or as soon as practically possible, by telephone and to prepare and send a written report thereof with 36 hours or receiving the information concerning the incident.

"Care custodian" means an administrator or an employee of any of the following public or private facilities: health facility, clinic, home health agency, educational institution, sheltered workshop, camp, respite care facility, residential care institution, including foster homes and group homes, community care facility, adult day care facility, including adult day health care facilities, regional center for persons with developmental disabilities, licensing worker or evaluator, public assistance worker, adult protective services agency, patient's right advocate, nursing home ombudsman, legal guardian or conservator, skilled nursing facility, intermediate care facility, local law enforcement agency, or any other person who provides goods or services necessary to avoid physical harm or mental suffering and who performs such duties.

I certify that I have read and understand this statement and will comply with my obligations under the child and dependent adult abuse reporting laws.

Signature of Volunteer: _____

Date: _____

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Vaccination Policy

To meet the requirements of SBNC policies and the Occupational Safety & Health Administration (OSHA), you will need proof of immunizations before beginning work or volunteer assignment/s at SBNC. Each employee or volunteer is responsible for providing a copy of his/her immunization record (if available). Required vaccinations vary according to the nature of the job or volunteer assignment.

Administrative Employee Group (defined as employees and volunteers with no direct contact with patients or public. Examples include accounting and development staff.)

No vaccination requirement.

Clinic Staff (defined as employees or volunteers performing tasks involving exposure to blood or bodily fluids and/or direct contact with patients. Examples include physicians, lab and medical technicians, dentists, and dental assistants.)

Vaccination Requirements:

Hepatitis B: 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Give IM. Obtain anti-HBs serologic testing 1–2 months after dose #3. (Unvaccinated new employees or volunteers must complete a 3-dose series and post-vaccination test showing immunity. If test result is negative, up to 3 additional doses of vaccine may be required.)

Influenza: One **(**1) dose of influenza vaccine annually. Inactivated injectable influenza vaccine intramuscularly or live attenuated influenza vaccine (LAIV) intranasal.

MMR: For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below. Give SC.

Varicella: For HCP who have no serologic proof of immunity, prior vaccination, or history of varicella disease **(chickenpox),** give 2 doses of varicella vaccine, 4 weeks apart. Give SC.

Tetanus, diphtheria: One-time dose of Tdap as soon as feasible to all HCP who have not received Tdap previously. **Pertussis**: Give Td boosters every 10 years thereafter. IM.

Tuberculosis: TB skin tests are required within 12 months prior to your start date at SBNC. One of these must be within 3 months of the start date. All existing employees with direct patient contact will receive an annual TB screening. Any worker found to have active pulmonary tuberculosis will be excluded from the workplace until he/she has received medical clearance.

Signature of Volunteer: _____

Date: _____

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Request for Required Vaccinations for Healthcare Personnel or Volunteers

I understand that due to my exposure to viral and bacterial infections as an employee or volunteer, I may be at risk. As a result, all employee and volunteers (with the exception of the Administrative Employee Group**)** must have the following immunizations completed:

Please attach a copy of any immunizations records that you have received along with this application

I DESIRE the following immunizations prior to beginning my assignment (check off):

IMMUNIZATIONS	DESIRED	COMPLETED
Influenza		
MMR		
Varicella		
Tetanus, diphtheria, pertussis (T-dap)		
Hepatitis B		
Hepatitis B surface antibody titer		
Tuberculin skin test (PPD) – May be declined only if you are receiving chest X-ray instead		

Signature of Volunteer: _____

Date: _____

If applicant is 16 or younger, applicant must have parent or legal guardian sign below:

Signature of Parent or Legal Guardian: _____

Date: _____

Signature of reviewer: _____

Date: _____

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Volunteer Waiver, Release and Indemnity Form

For and in consideration of the opportunity to participate in the volunteer program offered by Santa Barbara Neighborhood Clinics, the undersigned hereby voluntarily releases, discharges, waives and relinquishes any and all actions or causes of action for the personal injury, property damage or wrongful death occurring to it arising as a result of the activities or services which the undersigned may engage in through the volunteer opportunities offered by Santa Barbara Neighborhood Clinics, or any activities incidental thereto, wherever or however the same may occur and for whatever period said activities or services may continue, and the undersigned does for himself or herself, his or her heirs, agents, executors, administrators and assigns hereby release, waive, discharge and relinquish any action or causes of action, aforesaid, which may hereafter arise for it, and agrees that under no circumstances will the undersigned or her or his heirs, agents, executors, administrators present any claim for personal injury, property damage or wrongful death against Santa Barbara Neighborhood Clinics or any of their parents, subsidiaries, officers, agents, servants, or employees for any of said persons, or otherwise.

IT IS THE INTENTION OF THE UNDERSIGNED BY THIS INSTRUMENT TO EXEMPT AND RELIEVE SANTA BARBARA NEIGHBORHOOD CLINICS FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE.

The undersigned, for herself or himself, her or his heirs, agents, executors, administrators agrees that in the event that any claim for personal injury, property damage or wrongful death shall be prosecuted against Santa Barbara Neighborhood Clinics, the undersigned shall indemnify and save harmless the same from any and all claims or causes of action by whomever or wherever made or presented for personal injuries, property damage or wrongful death.

The undersigned acknowledges that she or he has read the foregoing and is fully aware of the legal consequences of signing this instrument.

Signature of Volunteer: _____

Date: _____

If applicant is 16 or younger, applicant must have parent or legal guardian sign below:

Signature of Parent/Legal Guardian: _____

Date: _____