Volunteer Application

Volunteer Services: 205-975-9126
www.uab.edu/1917clinic

Thank you for your interest in serving at the UAB 1917 Clinic.
Please complete all portions of this application.
Return by email: Shirley Selvage sselvage@uabmc.edu
By mail: UAB 1917 Clinic, 3220 5th Ave South, Birmingham, AL 35222

Name: _____

Mailing Address: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

E-mail Address: _____ Date of Birth: _____

Emergency Contact Name:_____ Phone: (___)_____

This application is intended to give us an understanding of your background and experience. We just want to know more about you!

Educational History

Type of School	Name	City, State	Dates Attended	Diploma/Degree/ Current Major
High School				
Vocational or Technical				
College or University				
Graduate School				
Other				

Employment History (approximate dates are fine)

Employer	City, State	Dates	Position

Volunteer History (approximate dates are fine)

Organization	City, State	Dates	Position/Duties

Please list three things you do well or enjoy doing. (Examples: good listener, computer skills, organizational skills, learning about HIV research, talking with people, sharing your story, making presentations)

1. _____

2. _____

3. _____

Please explain why you want to be a volunteer at the 1917 Clinic?

_____

_____

What days and times could you be available? (Please check all that apply. Most opportunities are available during normal clinic hours. Some outreach opportunities may be available on nights and weekends.)

Day/Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings							
Afternoons							
Evening							

What opportunities are you interested in: (check all that apply)

In Clinic: ☐Birthday Caller ☐Clinic Host ☐1917 Greeter ☐Resource Center Host
Outreach: ☐(SHAPE) Educator ☐HIV Test Counselor ☐Outreach Event Volunteer
Advisory/Action Boards: ☐Patient Advisory Board (PAB) ☐ Research Community Advisory Board
☐United Community Advisory Board (UCAB)

If you are accepted as a member of the volunteer team, are you able to make an initial commitment of at least six months, four hours per week? (in-clinic volunteers **only**) ☐ Yes ☐ No
If no, how much time could you commit? _____

Have you ever been convicted of a crime (felony or misdemeanor) ☐ Yes ☐ No
If yes, please explain: _____

How did you hear about our Volunteer Program? _____

References - Please list two professional references who we may contact.
Note: If you are a patient at the 1917 Clinic please include at least one member of your healthcare team (provider, nurse, social worker, counselor).

Name of Reference	E-mail / Phone	Relationship

_____ _____
Signature certifying all information is correct and granting permission to verify answers. **Date**

Date received:_____ Start date:_____Position: _____

Volunteer Agreement

- I understand that if selected I will have to:
  - provide information necessary to conduct a background check
  - provide proof of current TB Skin test
  - complete online HIPAA training
- I agree to adhere to the 1917 Clinic's Confidentiality Policy which states that I will not discuss or acknowledge any identifying factors regarding 1917 Clinic consumers, including those receiving medical care/treatment, HIV Testing, or other individuals living with HIV, to anyone outside of the 1917 Clinic.
- I fully understand that the services I provide the 1917 Clinic are to be given without any expectation of personal remuneration or gain of any kind, financial or otherwise.
- I agree to provide considerate and respectful care for any consumer of the 1917 Clinic, without prejudice or discrimination. I agree to provide services in a non-judgmental manner without regard to sexual orientation, gender, race/ethnicity, religion, physical capabilities, educational level, political opinion, residential or socio-economic status.
- I agree to make to an on-going commitment to educating myself about HIV/AIDS related topics through my volunteer placement and by attending clinic and community events as I am able.
- I agree to be receptive to constructive suggestions and supervision. I agree to bring any problems that may arise in the course of my volunteer service directly to the appropriate staff for resolution.
- I agree to abstain from using alcohol or other substances when performing duties for the 1917 Clinic.
- I agree to fulfill my specific volunteer responsibilities to the best of my ability.

Assumption of Risk and Hold Harmless Agreement

For, and in consideration of being permitted to participate as a volunteer at UAB 1917 (HIV/AIDS) Outpatient Clinic, the undersigned, in full recognition that a clinic environment may present various risks to health and safety, assume all the risks and responsibilities of my participation as a volunteer, and any activities undertaken an hereby agree to hold harmless, release, and forever discharge the Board of Trustees of the University of Alabama (the Board), the University of Alabama at Birmingham (UAB), every division thereof, employees, and agents, and the University of Alabama Health System, from any and all claims, demands, and actions, or causes of action, on account of damage to personal property, personal injury or death, which may result from my participation as a volunteer, and which result from causes beyond the control of, and without the gross negligence of the Board and UAB, its officers, employees or agents, and/or the University of Alabama Health System, during the period of my participation as a volunteer at UAB 1917 Clinic.

I have read all the parts of this agreement and have entered this agreement as a volunteer for the 1917 Clinic.

_____	_____	_____
Volunteer Name (Print)	Volunteer Signature	Date
_____		_____
Signature of Parent/Guardian if Volunteer is under 19 years of age		Date
_____		_____
1917 Clinic Staff		Date

The 1917 Clinic
a member of the UAB Health System

Confidentiality Agreement
UAB 1917 Clinic & Division of Infectious Diseases

Full Name: _____

Degree(s) earned: _____

☐ Resident ☐ Fellow ☐ New Hire ☐ Student / Intern ☐ Volunteer ☐ Visitor

IMPORTANT: Read all sections. If you have any questions, please ask them before signing. A copy of this signed agreement will be kept on file at the 1917 Clinic and the Division of Infectious Diseases.

DISCLOSURE OF PATIENT/PROVIDER INFORMATION

I recognize that the services provided by the University of Alabama Health Services Foundation, P.C. (UAHSF) and the University of Alabama at Birmingham for its patients are private and confidential; that to enable the UAHSF/UAB to perform those services, patients furnish information to the UAHSF/UAB with the understanding that it will be kept confidential and used only by authorized persons as necessary in providing these services; that the good will of the UAHSF/UAB depends on keeping services and information confidential; that certain legal obligations attach to this information; and that by reason of my duties or in the course of my employment I may receive or have access to verbal, written, or electronic media information concerning patients and services performed by the UAHSF/UAB even though I do not furnish the services performed for those patients.

I hereby agree that, except as directed by the UAHSF/UAB or by legal process, I will not at any time, during or after my employment or during my duties at the UAHSF/UAB, disclose any such services or information to any unauthorized person, or permit any such person to examine or make copies of any reports or other documents prepared by me, coming into my possession or control, or to which I have access, that concerns in any way the patients of the UAHSF/UAB. I agree that I will not attempt to use any information for my own advantage.

I recognize that the unauthorized disclosure of the information by me may violate state or federal laws and do irreparable injury to the UAHSF/UAB or to the patient, and that the unauthorized release of information may result in disciplinary action or dismissal.

SECURITY OF UAHSF INFORMATION/EQUIPMENT

I agree that I will comply with all security regulations in effect at the UAHSF/UAB.

I understand that all software used on a computer owned by the UAHSF/UAB must be properly licensed and approved by UAHSF/UAB Administration for use on that computer. The use of unlicensed or unapproved software constitutes a serious risk to UAHSF/UAB operations. If I use or allow to be used any unlicensed or unapproved software on a UAHSF/UAB computer, I will be subject to disciplinary action or dismissal.

If I have received a sign-on code allowing me to use a computer for UAHSF/UAB business, I agree that I will not disclose and will protect the information and property of the UAHSF/UAB.

I have read all of the above sections of this agreement and I understand them.

SIGNATURE: _____ DATE: _____

SIGNATURE OF WITNESS: _____ DATE: _____