

Hawaii H.O.M.E. Project Volunteer Application (Please complete in full)

GENERAL INFORMATION

1. Name: _____

2. Date of Birth: _____/_____/_____

3. Address:

4. Home Phone: (_____)_____ Cell Phone: (_____)_____

5. Email Address: _____

6. Please check one:

Medical Student

Pre-med Student

Resident

Nursing Student

LPN/RN/NP

Med Tech

SW Student

Pharmacist

Physician

Other: _____

7. If you are not medically trained, in what capacity would you like to volunteer at the clinic?

8. Do you have any special skills/talents that may be useful to the project (i.e. computers, website development, graphics, marketing, etc.)?

9. What foreign languages can you speak?

10. What are the days of the week and hours of the day that are most convenient for you to volunteer?

HEALTH STATUS

Yearly review of health status is required of all clinic volunteers for the health and safety of our patients.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you currently have any physical or mental impairments that could limit your clinical practice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a potentially communicable disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been hospitalized for any reason during the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently or have you ever been under formal mental health therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you currently under or have you ever received treatment for an alcohol or drug related condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been involved in the unlawful use of controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

AUTHORIZATION TO RELEASE VOLUNTEER INFORMATION

Your consent is requested for the following information:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. I authorize the Hawaii H.O.M.E. Project to print my name as a volunteer in information produced and distributed by the organization or the University of Hawaii John A. Burns School of Medicine. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I authorize the Hawaii H.O.M.E. Project to use pictures/videos of me while in the service of the clinic for the use of promoting the project and/or it's mission | <input type="checkbox"/> | <input type="checkbox"/> |

FOR LICENSED PROFESSIONALS ONLY

Educational History:

1. School/Institution: _____

2. City & State: _____

3. Year Graduated: _____

4. Certificate/Degree: _____

Additional:

5. Current place of employment: _____

6. Hawaii Licensure Number: _____

7. Expiration Date: _____

****PLEASE ATTACH A COPY OF YOUR CURRENT LICENSE****

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has your license to practice, in any jurisdiction, ever been suspended or not renewed? If yes, please explain in full detail on the back of this form. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I have checked with my malpractice carrier and I am covered for volunteer clinical services. If No, by signing here, I am acknowledging that the Hawaii H.O.M.E. Project does not supply malpractice coverage for me and that I am only protected to the extent allowable by the Federal Charitable Immunity Act. | <input type="checkbox"/> | <input type="checkbox"/> |

Signature: _____

By signing below, I attest that all of the information provided on this application is accurate.

1. Signature: _____

2. Date: _____/_____/_____

3. Printed Name: _____

Mail completed application (with Letter of Agreement) to:

Jill Omori, MD
Hawaii H.O.M.E. Project
651 Ilalo Street
MEB-OME
Honolulu, HI 96813