BULLARD MISSION HOUSE AND MISSION CLINIC

307 W. CAIN ST.
BULLARD, TX 75757
PHONE 903-894-0109 FAX 903-894-3411
info@bullardmission.org

BULLARD MISSION CLINIC VOLUNTEER APPLICATION FORM

PERSONAL INFORMATION

LAST NAME: _____ FIRST NAME: _____ D.O.B.: _____

ADDRESS: _____

HOME PHONE: _____ MOBILE PHONE: _____

EDUCATION

Highest level completed: High School: _____ College: _____ Post Graduate: _____

COLLEGE AND LOCATION: _____

Year of Graduation: _____ Degree: _____

POST-GRADUATE UNIVERSITY AND LOCATION: _____

_____

Year of Graduation: _____ Degree: _____

PROFESSIONAL DEGREE - UNIVERSITY AND LOCATION: _____

_____

Year of Graduation: _____ Degree: _____

PROFESSIONAL LICENSE: _____

Name issue in: _____ Expiration: _____

SPECIAL COURSES OR TRAINING: _____

_____

WORK EXPERIENCE: _____

_____

_____

_____

_____

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

SIGNATURE: _____ **DATE**: _____

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CONFIDENTIALITY STATEMENT

The Bullard Mission House and Mission Clinic and its volunteers have a policy of patient/client confidentiality.

Confidentiality of all records shall be maintained. No information obtained in connection with the examination, care, or provision of programs or services to any person shall be disclosed without the individual's written consent, except as may be required by law, such as the reporting of communicable disease. Information may be disclosed in statistical or other summary form, but only if the identity of the individual diagnosed or provided care is not disclosed. All requests for information must be processed through Administration.

I am aware that the Health and Safety Code, §81.103, provides for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law. Furthermore, all employees and volunteers who provide direct patient/client services or handle direct care records wherein they may be informed of a patient/client's status or any other information related to the patient/client's care, are required to sign a statement of confidentiality assuring compliance with the law.

_____ _____

Department Head—Witness Volunteer/Employee

_____

Date

I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

SIGNATURE: _____ **DATE**: _____