Remote Area Medical-Wise, VA Volunteer Registration Form

Your role in program: ☐ Professional Volunteer (profession/medical license) ☐ General Volunteer

Name_____Organization (if applicable) _____

Address_____City_____ State_____ Zip_____

Day Telephone_____ Mobile Phone_____Fax_____

Email_____

Days you are volunteering, check all that apply:

Clinic Days: ____Thur. (7/18)patient registration only _____Friday (7/19) _____ Saturday (7/20) _____ Sunday (7/21)

Past RAM Wise Volunteer: ☐ Yes ☐No Past Job Assignment: _____

Are you coming to participate in this event through: Lions Club? ☐ Yes ☐ No Student? ☐ Yes ☐ No

If student, which college/university?_____Name of preceptor attending?_____

Compliance Statement: I hereby attest that my license/certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. A COPY OF MY CURRENT STATE LICENSE OR CERTIFICATE AND DEA# (where applicable) ARE ATTACHED HERETO. If functioning as a Nurse Practitioner you are required to have a separate practice agreement for this event. Please attach a copy of this agreement.

Confidentiality Statement: I as a professional or general volunteers working at the RAM event shall maintain the privacy and confidentiality of all information relating to participants in the RAM; shall not disclose participant information to any third party other than RAM Headquarters and the Health Wagon, including a volunteer participating in RAM who does not have a need to know the participant information; shall not use participant information for any purpose except for those related to RAM event, participant follow-up, and evaluation; and after complying with the obligations set out, shall not retain any participant information, except that RAM/Health Wagon may retain the names and addresses of participants only to contact them about RAM/Health Wagon activities. This confidentiality obligation applies even if some or all of the participant information may be available from public sources. This pertains to all present and future written and verbal communications referring to any RAM patient. I also understand that unless I am obtaining information strictly for patient registration or for follow-up care, I will not ask a patient any question regarding medical insurance coverage, Medicare and Medicaid.

Release and Indemnification Statement: I hereby release and indemnify Remote Area Medical® and the Health Wagon, non-profit organizations, and all its respective officers, directors, agents, contractors, heirs, successors and assigns, from prosecution or presentation of any claim for bodily injury or death or for property loss or damage incurred in connection with this Remote Area Medical® expedition or related activities.

Profession_____License Number _____State(s) _____

If returning volunteer: Describe your specific job assignment performed in the past and what area you worked _____

_____

Potential Exposure to Blood Borne Pathogen: I fully understand that I am volunteering at my own risk and that due to my occupational/other possible exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection or other blood borne pathogens I agree that if exposed to blood borne pathogens or other potentially infectious materials during the event conducted pursuant to the RAM event, I will follow the guidelines recommended by the Centers for Disease Control regarding post exposure treatment. I understand that failure to follow the guidelines in the event of percutaneous exposure with a potentially contaminated needle or instrument, or a splash of blood or other potentially contaminated material to non-intact skin, mucous membranes, etc. during the course of work significantly increases chances of infection.

Professional volunteers please check one below:

_____ I have received the vaccination for Hepatitis B.

_____ I have not received the vaccination for Hepatitis B and I am hereby wave to have this vaccination of my own free will. I understand if I do not have the HBV vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I want to be vaccinated with Hepatitis B vaccine, I can acquire the vaccination at my own expense and understand that my immunization series should be completed at least 6 months before I plan to volunteer.

Blood Borne Pathogen Training: Blood borne training is required for all medical and dental volunteers. I hereby certify that I have completed a training/educational program on the risk of exposure to blood borne pathogens and methods to prevent exposure.

_____ _____ _____

Printed Name Signature Date

Please return form and copy of current license (if applicable) to:

Health Wagon, POB 7070 Wise, VA 24293, email: ram@thehealthwagon.org, fax: 276-328-8853 Questions, please call 276-328-8850.

Remote Area Medical® is a 501(c) (3) medical relief charity located at 1834 Beech Street, Knoxville, TN 37920

OFFICE USE ONLY: Copy of License Received ☐ Yes Date: _____ Copy of License Verified ☐ Yes

Out of State Temporary License: Copy of License received ☐ Yes

Nurse Practitioner: Practice Agreement received ☐ Yes Verified By: _____ Revised 3/26/13