



Mercy Medicine
514-E South Dargan Street
Florence, SC 29506

"I was sick and you cared for me." Matthew 25

Phone (843) 667-9947
Fax (843) 667-0455

Volunteer Information Form

Last Name _____ First Name _____ M.I. _____

Home Address _____

City _____ State _____ Zip _____ DOB _____

Home Phone _____ Work Phone _____

Place of Employment _____

Job title / duties _____

Church Affiliation _____ Pastor's Name _____

Please indicate the type of volunteer service you can offer:

- LPN Physician Pharmacist Receptionist Computer operator
 RN Nurse Practitioner Pharmacy Tech Screener Other _____

Additional training and/or skills which you feel will enhance your services here at Mercy Medicine Clinic

Days available for volunteering Monday Tuesday Wednesday Thursday Friday

Have you had a TB screening test in the past year? Yes No Date _____

Have you been vaccinated for Hepatitis B? Yes No Date _____

Please list two references (personal & professional) that can verify your experience

Are you currently an active volunteer? _____ How long have you been a volunteer? _____

Emergency Contact _____

Telephone _____

Signature _____

Date _____

MERCY MEDICINE CLINIC Confidentiality Policy

Maintaining patient confidentiality and dignity is of utmost importance in the Medical Ministry. Client records will be kept on all individuals requiring our services. The staff and volunteers will consider all information gathered about a client as private and confidential. All records are the property of Mercy Medicine Clinic.

Confidentiality will be kept by the following guidelines:

- No information will be public knowledge without the written or direct oral consent of the individual.
- General information may be shared with a pastor or other professional (social worker, attorney, physical, etc.) who is working on behalf of the patient, and for whom the patient has consented the release of information.
- No one other than a staff member or volunteer trained for counseling or interviewing can solicit information from patients on the premises of Mercy Medicine Clinic. Violation of these guidelines will result in a “request to leave” by the Medical Director or Clinical Coordinator.
- Violation of confidentiality will be considered sufficient reason to terminate employment or volunteer activities.

I have read and understand Mercy Medicine Clinic’s policy on confidentiality.

Volunteer Signature _____

Date _____

**Thank you and God bless you for your interest in volunteering at
Mercy Medicine Clinic!!**

FOR MERCY MEDICINE CLINIC USE ONLY

License Information

Licensed as: Physician LPN Pharmacist Expiration date _____
 Nurse Practitioner RN Social Worker

Orientation date _____

Provided by _____