Mariam Clinic Volunteer Application

Phone: 919-824-4672 **Fax:** 919-439-3778

9/8/2026

Thank you very much for your interest in volunteering. We are dedicated to providing quality healthcare for the uninsured in our community. If you would like to join us in this effort, please fill out this application and email the completed form to clinicadmin1@mariamclinic.org. This information will be used to contact you in the future.

Date: _____ Name: _____

Address: _____ Phone: _____

Date of Birth: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Please describe why you want to volunteer and what you hope to achieve from being involved in the Mariam Clinic:

_____

_____

_____

Please describe what interests, talents, and skills you would like to share with the Mariam Clinic:

_____

_____

_____

Please list any languages you consider yourself fluent in (please do not list list any languages you cannot hold a conversation with a patient in):

_____

Please list your health certifications, license number and expiration date. (i.e. CNA, MA, LPN, RN, Phlebotomist etc.):

- ☐ **None**
- ☐ **Certifications:** _____

Which volunteering positions are you interested in? Please refer to position descriptions for details on each role.
If you are interested in more than one position, rank your preferences (1 for first choice, 2 for second choice, etc.):

- ☐ **Clinic Volunteer**
  Ranking: _____
- ☐ **Patient Navigator**
  Ranking: _____
- ☐ **Outreach Volunteer**
  Ranking: _____

For each volunteer role, the Mariam Clinic has position-specific requirements. Please fill out and agree to the policies for each position that you are interested in:

Clinic Volunteer

Start date: _____

Commitment level - please initial: Minimum of **2 Sundays**/month **_____** Minimum of **6 months**: **_____**

☐ **I understand that I must commit to a minimum of 6 months. Since my training will consist of 3-4 consecutive Sundays, I have chosen my start date to reflect my availability to complete my training.**

Since we are a free clinic and depend upon the reliability of our volunteers, we ask that all volunteers fill out the availability form by the due date requested. **Initial: _____**

If a volunteer can't make their assigned shift, they must find a replacement. If they are unable to do so they must notify the administration with the list of names they have contacted. If a volunteer fails to show up for their shift twice without notice they will no longer be able to volunteer and will not receive a letter of recommendation. **Initial: _____**

Volunteers should arrive **30 mins** prior to the clinic open dressed in scrubs or business casual. **Initial: _____**

Patient Navigator

Start date: _____

Commitment level - please initial: 3–10 hours per week: **_____** **5–15 patients**, assigned based on your capacity and clinic need: **_____**

☐ **I understand that I must commit to a minimum of 12 months. Since my training will consist of 2-3 consecutive Sundays, I have chosen my start date to reflect my availability to complete my training.**

Outreach Volunteer

Start date: _____

Commitment level - please initial: Minimum of **1 outreach event**/month **_____** Minimum of **6 months**: **_____**

☐ **I understand that I must commit to a minimum of 6 months. Since my training will consist of 2-3 consecutive Sundays, I have chosen my start date to reflect my availability to complete my training.**

Since we are a free clinic and depend upon the reliability of our volunteers, we ask that all volunteers fill out the availability form by the due date requested. **Initial: _____**

If a volunteer can't make their assigned shift, they must find a replacement. If they are unable to do so they must notify the administration with the list of names they have contacted. If a volunteer fails to show up for their shift twice without notice they will no longer be able to volunteer and will not receive a letter of recommendation. **Initial: _____**

By signing below, I agree that I have read and will abide by all of the policies and rules stated.

Signature: _____ **Date:** _____

Name Printed: _____

HIPAA Privacy and Confidentiality Statement

I understand that as a volunteer at Mariam Clinic, I will see, hear, and/or otherwise have access to confidential healthcare information and other privileged documents. As such, I understand and agree that I must review and adhere to the guidelines listed below and to the items attached to this statement. Volunteers and employees alike have a legal and ethical responsibility to foster and maintain the privacy and respect of each patient we see here at the Mariam Clinic.

Background:

1. HIPAA stands for the "Health Insurance Portability & Accountability Act" of 1996.
2. It was created to protect individuals' medical records and personal health information at the National standard.
3. Today with information broadly being held and transmitted electronically, the Privacy and Security Rules under HIPAA provide the protection of personal health information.
4. HIPAA applies to any organization that routinely handles protected health information (PHI) in any capacity, such as hospital, physician practice, lab, etc. This includes the entity where the student will be spending time. The health care entities at Mariam Clinic require its staff, both clinical and non-clinical, volunteers, students, and visitors to keep health information confidential.

What areas are affected?

1. Any and all areas that deal with Protected Health Information (PHI).
2. Could include areas in which one might not directly car for patients.
3. Includes testing results, research, and billing records that contain health information.
4. Students, trainees, volunteers, and other persons who have access to PHI are affected.
5. Includes what you store on computers, desks, files, off-site storage, disks, etc.
6. Affects what you say, to whom it is said, and what information you are providing.

What is Protected Health Information (PHI)?

1. Any health information that identifies an individual
2. Names
3. Geographic designations smaller than a state
4. Dates relating to the individual
5. Telephone numbers
6. Fax numbers
7. Email addresses
8. Social Security numbers
9. Medical Record Numbers
10. Health Plan Beneficiary numbers
11. Account numbers
12. Certificate/license numbers
13. Vehicle identifiers, including license plates
14. Device identifiers
15. Universal resource locators (URLS)
16. Internet Protocols (IP) address numbers
17. Biometric identifiers- finger & voice prints
18. Full-face photographic images & comparable images
19. Any other unique identifying numbers, characteristics, or code.

PHI can be in any form including:

1. Printed
2. Electronic
3. Oral communication

PHI includes information that:

1. Is collected from an individual.
2. Is created or received by a covered entity.
3. Relates to the past, present, or future physical or mental health condition of an individual.
4. Relates to the provision of health care to an individual.
5. Relates to the past, present, or future payment for the provision of health care to an individual.
6. Identifies an individual.

What are the minimum necessary requirements?

1. HIPAA requires that you take reasonable steps to limit the use, disclosure or, and requests for PHI to the minimum necessary in order to accomplish the intended purpose.
2. What PHI is reasonably necessary is determined on a case by case basis by individual covered entities.
3. This does not apply to disclosures for treatment purposes, but to payment, health care operations and research.

What happens if you violate the Privacy Rule?

1. Civil penalties ($100 per violation per person, up to a limit of $25,000 for violating each identical requirements or prohibition).
2. Criminal penalties:
    1. Knowing release of PHI= up to 1 year jail sentence & $50,000 fine.
    2. Access to PHI under false pretenses= up to 5 year jail sentence and $100,000 fine.
    3. Releasing PHI with intent to sell, transfer, or use for commercial advantage= up to 10 year jail sentence & $250, 000 fine.

What are my responsibilities?

1. To not disclose any protected health information. This includes any written, verbal or electronic information I may have directly or indirectly received or overheard.
2. When coming in contact with a patient, introduce myself as a volunteer.
3. To NOT misrepresent myself as a health care provider who will be assisting in a patient's care.
4. To NOT misrepresent myself as a medical student or a resident if you aren't.
5. To wear a name tag or badge identifying me as a volunteer and what position you are.
6. To respect the patients' privacy.
7. To NOT copy, download, or access any protected health information.

I agree that my responsibility to keep this information confidential extends beyond my volunteer experience and continues indefinitely.

By signing below, I represent that I have read and understand that I am obligated to maintain the protection of patient privacy and other confidential matters at the Mariam Clinic. Any confidential health care that I may see, hear, or otherwise access cannot be disclosed.

I hereby **certify that I have read this document** and am aware of the confidentiality requirements expected of me.

Signature: _____ **Date:** _____

Name Printed: _____

Policy on Hepatitis B Vaccination Series

Employees and volunteers working in direct patient care areas will be asked to provide evidence of having received the Hepatitis B vaccine series, agree to receive the vaccine, or sign a waiver to refuse the series.

☐ **I have received the Hepatitis B vaccination series and have included a copy of my vaccines record**
☐ **I agree to receive the Hepatitis B vaccination series and will provide a copy of my vaccines record prior to volunteering**

Signature: _____ **Date:** _____

Name Printed: _____

☐ **I have read the statement below and will be declining the Hepatitis B vaccination series at this time**

I, _____, am a volunteer as a health care provider at Mariam Clinic. I am aware and understand the effectiveness of Hepatitis B immunization, the risk of contracting Hepatitis B, and the importance of taking active prevention to reduce the risk. However, I, of my own free will and volition, and despite the Clinic's urging, **have elected not to be vaccinated against Hepatitis B**. I have personal reasons for making the decision not to be vaccinated.

Signature: _____ **Date:** _____

Name Printed: _____

Documents to be Submitted with your Application

The following documents must be submitted with your application:

1. **Photo ID**
2. **A copy of any professional licenses**
3. **Immunization record**
4. **Copy of COVID-19 vaccination card**

CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement ("Agreement") is made effective as of _____ between **Mariam Clinic** ("Practice"), and _____ "Staff").

Staff acknowledges that being a member of the workforce of Practice, they could/will/might be processing and working with information dealing with a wide range of attributes. Staff hereby accepts that job roles and duties for all workforce members are subject to change as Practice sees fit.

Staff will protect any and all information that they receive or may encounter whether health-related information or other individually identifiable information, and will also protect with the same vigor Practice business information. Staff will also comply with the HIPAA Rules related to Privacy and Security and further details set forth by Practice. Under these requirements, Staff is to protect against the impermissible disclosure of any patient's Protected Health Information to an unauthorized third party.

Practice has requested that Staff will protect the confidential material and information which may be disclosed between Practice and Staff. Therefore, the parties agree as follows:

1. CONFIDENTIAL INFORMATION. The term "Confidential Information" means any information or material which is proprietary to Practice, whether or not owned or developed by Practice, and which Staff may obtain through any direct or indirect contact with Practice. Confidential Information includes without limitation:
   a. Protected Health Information of patients and employees
   b. Practice records and plans
   c. Financial statements
   d. Patient lists and records
   e. Technical information
   f. Computer programs and listings
   g. Source code and/or object code
   h. Copyrights and other intellectual property
   i. Other proprietary information

2. PROTECTION OF THE CONFIDENTIAL INFORMATION. Staff understands and acknowledges that the Confidential Information, including but not limited to passwords, access codes and keys, has been developed or obtained by Practice by the investment of significant time, effort and expense, and that the Confidential Information is a valuable, special and unique asset of Practice which will affect the

Practice if improperly disclosed. Staff agrees to secure any equipment or information prior to leaving it unattended by methods such as: locking a door, logging off a computer, etc. In consideration for the disclosure of the Confidential Information, Staff agrees to hold in confidence and not to disclose the Confidential Information to any person or entity without the prior written consent of Practice. In addition, Staff agrees that:

a. No Copying/Modifying. Staff will not copy or modify any Confidential Information without the prior written consent of Practice.

b. Unauthorized Disclosure of Information. If it appears that Staff has disclosed or has threatened to disclose Confidential Information in violation of this Agreement, Practice shall be entitled to an injunction to restrain Staff from disclosing, in whole or in part, the Confidential Information. Practice shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages.

3. RETURN OF CONFIDENTIAL INFORMATION. Upon the written request of Practice, Staff shall return to Practice all written materials containing the Confidential Information. Staff shall also deliver to Practice written statements signed by Staff certifying that all materials have been returned within five (5) days of receipt of the request. Staff will continue confidentiality obligations to Practice after the termination of employment or contract.

4. PROTECTED HEALTH INFORMATION. Protected Health Information, or PHI, means individually identifiable health information. 'Identifiable' refers not only to data that is explicitly linked to a particular individual but also includes health information with data items which reasonably could be expected to allow individual identification.

'Health Information' relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual that is transmitted or stored in any form.

PHI may be disclosed to only those parties that have proper authority and only for those purposes for which Practice has authority to disclose it:

a. Do not disclose PHI to a group administrator unless either (1) the group is fully compliant with HIPAA Privacy regulations as an "Involved Sponsor" or (2) Patient or dependent has signed a written authorization to release the information.
b. PHI may be disclosed to any Covered Entity (provider or health plan) or Business Associate of a Covered Entity with whom Practice is directly or indirectly contracted.
c. PHI may only be disclosed for purposes related to Treatment, Payment or Health Care Operations and in those situations should only disclose the minimum

necessary information to accomplish the intended use.

d. Other specific uses and prohibitions may arise – Staff should check with their supervisor for additional direction.

5. DOCUMENTING BREACHES. Under regulatory and contractual obligation, Practice is required to report any unauthorized disclosure of Protected Health Information to the various regulatory agencies (e.g. U.S. Department of Health & Human Services, U.S. Department of Labor). As a result, Staff is to immediately notify supervisors of a breach.

6. DISCIPLINARY ACTION FOR BREACHES. Since Practice is required to report these breaches and Staff acknowledges that any breach will result in some impact on Practice, Staff must be aware that a breach of privacy obligations will be documented in their files and that corrective action may be taken as a result. The range of possible corrective actions include but are not limited to reprimand, oral and/or written warning, suspension, termination of employment, or cessation of ongoing business relationship.

7. MINIMIZING THE IMPACT OF A BREACH. Practice is required to take corrective action immediately to mitigate or reduce the impact of the breach to any patient. Staff understands that they have an obligation to assist in that effort which will include providing all known information about the breach, including but not limited to the individual(s) impacted, the nature of the breach, individual(s) who may have had the opportunity to obtain the information, how to best communicate with all parties to resolve the breach and how to prevent future breaches of similar nature.

8. RETALIATORY ACTION. To ensure receiving all information necessary to minimize the impact on Practice and patients and to allow reporting in a timely fashion, Staff is encouraged to report any known breach to the proper individuals within the Practice. Intimidation, coercion, threats, discrimination or retaliatory actions against individuals who report breaches or are involved in a breach of privacy obligations is prohibited and appropriate measures will be taken to protect against the identification by someone who is being accused of breaching privacy obligations.

9. SECURITY. Practice is committed to protecting against the disclosure of patient data that may be contained in physical or electronic form and will take all reasonable administrative, physical and technical measures to provide security over that information. Practice will safeguard and protect Protected Health Information maintained or transmitted in electronic form and maintained in physical form within their control. Staff must take similar measures, including but not limited to Staff member's home, non-co-located office, personal possessions or your motor vehicle(s).

   Practice will meet regulatory and contractual obligations regarding security as follows :

a. All reasonable means to protect the confidentiality, integrity and availability of all electronic PHI which is received, created, maintained or transmitted;
b. Defend against any reasonably anticipated threats or hazards to the security and integrity of information over which there is control;
c. Defend against any reasonably anticipated uses or disclosures of information that are not permitted or required under various regulatory or contractual obligations; and
d. Ensure that Staff understand and follow these rules and guidelines and if they fail to do so, then appropriate measures will be taken to correct the violation, as well as, any disciplinary action necessary.

10. GENERAL PROVISIONS. This Agreement sets forth the entire understanding of the parties regarding confidentiality. Any amendments must be in writing and signed by both parties. This Agreement shall be construed under the laws of the State of North Carolin a. This Agreement shall not be assignable by either party, and neither party may delegate its duties under this Agreement, without prior written consent of the other party. The confidentiality provisions of this Agreement shall remain in full force and effect after the effective date of this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and affixed their respective seals as of the day and year first above written.

Mariam Clinic ("Practice")

By: _____ _____
Authorized person in Practice Printed Name/ Title

I have read the Agreement and agree to comply with all of its terms as a condition of my continued business relationship with the Practice.

STAFF MEMBER

_____
Signature

_____
Printed Name