



VOLUNTEER APPLICATION

General Medical and Others: Social Workers, Clerical, Medical Assistants, Medical Students, etc.

(APPLICATION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE PROCESSED)

Last Name: _____ First Name: _____

Address: _____

Email: _____

Phone: _____ Cell: _____ Pager: _____

Drivers License Number: _____ Social Security Number: _____

Please Include Copy of License

Date of Birth: _____ Fluent Languages: _____

Area of Interest: _____

Employer: _____ Reference: _____

Reference: _____

Release of Information Authorization

I _____ hereby acknowledge that all information provided on this volunteer application is accurate and authorize Surgery On Sunday, Inc. to verify all information herein.

APPLICANT SIGNATURE

DATE

Surgery On Sunday, Inc. Confidentiality Agreement

Surgery On Sunday, Inc. follows and adheres to all professional medical guidelines including the Health Information Portability and Accountability Act (HIPAA) of 1996. As a Surgery On Sunday, Inc. volunteer I understand and agree that all information pertaining to Surgery On Sunday, Inc. patients and volunteers must be kept strictly confidential. Any violation of this agreement will result in my immediate termination as a Surgery On Sunday volunteer and may involve legal repercussions.

I will not hold Surgery On Sunday, Inc. or any Surgery On Sunday staff member, volunteer or patient liable for any personal injury or loss of personal property while participating in the Surgery On Sunday, Inc. volunteer program.

Volunteer Signature

Date

Witness Signature

Date