

MEDICAL | DENTAL | PHARMACY | BEHAVIORAL HEALTH

EYE CLINIC | OPS CLINIC | DIABETIC EDUCATION | WELLNESS/NUTRITION | CASE MANAGEMENT | MEDICATION MANAGEMENT | HOPE INITIATIVE

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Dear Volunteer Provider,

Since 1974, Bradley Free Clinic has been a helping hand in the community, serving as the safety net for low-income, uninsured persons in our area. Over 3,000 patients receive no cost medical, pharmacy, dental and behavioral health services each year, thanks to a robust network of 300 medical professionals, volunteers like you.

We greatly value your volunteer commitment and want you to have every confidence when deciding to give your time and care for patients in our community. That is why we register each volunteer with the Virginia Division of Risk Management. Per Statute 54.1-106 in the Code of Virginia (copy attached): v

- The state attempts to protect you as a volunteer from liability for services rendered unless "gross negligence or willful misconduct" is involved/
- The state considers you... "deemed an agent of the commonwealth."

Bradley Free Clinic also provides coverage for the clinic through a Free Clinic policy written with Hudson Specialty. This provides an additional layer of protection for the clinic and for the volunteers who see/treat patients at the clinic.

By acquiring this coverage, we were able to ensure:

- Medical Professional liability coverage on an incident sensitive form (in addition to the claim reporting form or demand for payment provided by VA Risk Management).
- Coverage/representation for any medical board hearings that may arise (especially those not included in VA Risk Management).
- Inclusion of additional HIPPA coverage as well as a small amount of cyber liability.

With both layers of coverage in place, the services you provide as a volunteer at Bradley Free Clinic are protected, and you operate as a provider in the same manner you would in any other clinical environment.

Please call 540-344-5156 or email janine@bradleyfreeclinic.com if you have any questions or concerns. Thank you for your support and compassion for our patients! I look forward to working with you.

Sincerely,



Janine Underwood
Executive Director

Date: _____

Bradley Free Clinic
Licensed Healthcare Volunteer Information 2023
(Please print clearly and fill in completely – thank you)

Name: (Last) (First) (MI)	DOB: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Transgender Preferred Pronouns: <input type="checkbox"/> she/her <input type="checkbox"/> he/him <input type="checkbox"/> they/them
Home Address: (street, city, state, zip)	Email:
Place of Employment:	Cell Phone:
Employment Address:	Work Phone:
Spouse/Partner's Name:	Spouse/Partner's Phone:
Emergency Contact/Relationship:	Emergency Contact Phone:
Recruited By:	Start Date:
Preferred Method of Communication: <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Call Cell <input type="checkbox"/> Call Work	Social Security Number:

Medical Information

Significant Medical Conditions:	
Allergies to any medications: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____	Any other allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____
Physician's Name, Address, and Phone Number:	

Professional Information:

Professional Information: <i>(Please check)</i>	
<input type="checkbox"/> Dentist <input type="checkbox"/> Dental Assistant <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Dental Student <input type="checkbox"/> Lab Tech <input type="checkbox"/> Medical Resident <input type="checkbox"/> Medical Student <input type="checkbox"/> Optometrist/Ophthalmologist <input type="checkbox"/> Pharmacist <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> CMA/MA <input type="checkbox"/> CNA/NA <input type="checkbox"/> MD/DO <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> PA <input type="checkbox"/> Psychiatry Resident <input type="checkbox"/> Psychiatrist <input type="checkbox"/> LPC <input type="checkbox"/> LCSW <input type="checkbox"/> Other Certifications: _____	
Physician (specialty): _____	
Are you licensed to practice medicine in Virginia? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously, but no longer	
Virginia License #: _____	NPI: _____
License Expiration Date: _____	DEA #: _____
DEA Expiration Date: _____	
Are you credentialed with Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously, but no longer	

Are you Board Certified? Yes No Previously, but no longer

If yes, Name of Board Specialty: _____

If previously, but no longer, describe prior board and circumstances: _____

Have you completed residency training? Yes No

If yes, Program name, location, and year completed: _____

If no, describe years of residency completed, specialty, and circumstances: _____

Have you ever been sanctioned, investigated, or had any judgement made against you by a State License Board?

Yes No If yes, describe event(s) and date(s) and identify the State Board: _____

Would you like to, and/or would you anticipate provider supervision of medical trainees at Bradley Free Clinic?

Yes No If yes, describe trainees and your preferences, and/or limitations: _____

Have you ever been convicted of a crime other than a minor traffic offense? Yes No

If yes, please explain: _____

Please attach the following items:

Resume/CV Driver's License/Photo ID Immunization Record CPR Certification License to Practice

Applicant Signature

Date

Review Committee Signature

Date

Box below to be filled in by Clinic

<p>Date entered into Bloomerang: _____</p> <p>Date entered into Civitas: _____</p> <p>Athena Access: <input type="checkbox"/> Yes <input type="checkbox"/> No Athena Username: _____</p> <p>Date all Paperwork Received: _____</p> <p>Date Began Volunteering: _____</p> <p>Staff Initials: _____</p>

Bradley Free Clinic Volunteer Agreement Form

Thank you for your interest in volunteering with Bradley Free Clinic to make sure low-income, uninsured individuals in the Roanoke Valley get the health care they deserve. The Bradley Free Clinic is committed to maintaining a high level of professionalism in the services we offer to our patients. Therefore, we ask volunteers to agree to the following.

As a Bradley Free Clinic volunteer, I agree to:

1. Attend any volunteer orientation that is offered to me and read and follow volunteer policies and guidelines.
2. Maintain strict confidentiality of Bradley Free Clinic patients, which means that I will not share any information about Bradley Free Clinic patients with anyone outside of Bradley Free Clinic.
3. Access and/or examine Bradley Free Clinic patient medical charts or other patient information only as the duties for which I offer my volunteer services necessitate (i.e., the “need to know” clause).
4. Treat patients with kindness and respect.
5. Not accept payment from patients for any service I provide as a volunteer.
6. Maintain appropriate dress code.
7. Uphold the mission of the Bradley Free Clinic.

I understand that to make my volunteer experience a positive one, the Bradley Free Clinic agrees to:

1. Treat its volunteers with respect and appreciation for giving their time and talents.
2. Keep volunteers safe while volunteering at the Bradley Free Clinic.
3. Provide adequate information and support from paid clinical staff.
4. Listen to and address volunteers’ concerns, ideas, and suggestions.

I understand that if I do not follow these requirements, I may be asked to not volunteer again with Bradley Free Clinic. I also understand that Bradley Free Clinic is not responsible for any lost, damaged, and/or stolen personal belongings on the property.

Printed Name of Volunteer

Signature

Date

Reviewer’s Signature

Date



Volunteer Disclosure Regarding Background Investigation

Bradley Free Clinic may obtain information about you from a third party consumer reporting agency for volunteer purposes. **You will be notified by the Health Administrator if a background investigation is required for your volunteer role.** Thus, you may be the subject of a “consumer report” which may include information about your character, general reputation, personal characteristics, and/or mode of living.

These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records (“driving records”), verification of your education or employment history, or other background checks.

You will have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you and request a copy of your report. If required, these searches will be conducted by **FirstPoint Background Screening Resources, Inc., 225 Commerce Place, Greensboro, North Carolina 27401. Tel. No. 1-877-425-4763; www.firstpointscreening.com.**

Signature

Date

Printed Name

DOB & last four of SSN

**Bradley Free Clinic
Media Permission and Consent Form**

In consideration of services rendered and to be rendered to me, and in the public interest, I

_____ (person to be photographed and/or interviewed and/or featured in newspaper article, or if dead, his or her surviving consort, or if none, his or her next kin; and if a minor, his or her legal guardian, as well as such minor) hereby give permission to the Bradley Free Clinic of Roanoke Valley, Inc., its staff, agents, and employees, and the media to take and use anywhere photographs or picture and information of (your name) _____ and hereby consent to their use of any lawful purpose and I hereby covenant not to sue Bradley Free Clinic of Roanoke Valley, Inc., its staff, agents, and employees, and the media at law or in equity to restrain or prevent the taking or use thereof for damages or any injures sustained by taking such actions.

Printed Name of Volunteer

Signature

Date

Printed Name of Reviewer

Reviewer Signature

Date