



ITHACA HEALTH ALLIANCE



Ithaca Free Clinic

ATTN: Volunteer Applications • P.O. Box 362 • Ithaca, NY 14851
p:607.330.1254 • f:607.330.1194 • e:clinic@ithacahealth.org

Volunteer Application Packet

Dear Prospective Volunteer,

Thank you for your interest in volunteering with the Ithaca Health Alliance. Since 1997, the IHA has provided thousands of dollars of grants and loans for healthcare expenses, and since 2006, has delivered over 7,000 conventional and alternative medical visits to over 3,900 patients at no charge. Our efforts are only possible because of our community of IHA members, and our devoted team of volunteers who contribute to all aspects of our operations. We are grateful that you would like to join us in our mission to facilitate access to health care for all.

Applications from medical providers are accepted on a rolling basis. As a medically integrated healthcare center, the Ithaca Free Clinic provides a broad range of modalities, conventional and alternative, to the diverse population of Tompkins County and surrounding areas. Please ensure that your completed application includes:

- Professional Curriculum Vitae or Resume
- Copies of state licenses and/or certifications
- Letters from 3 references or contact information for 3 references
- IHA Code of Conduct signed

Applications for Clinic Administration positions are accepted at any time; however, positions typically become available three times a year (Fall, Spring, and Summer). Applicants should ensure their Application and Code of Conduct have been received by the following dates for consideration:

- Fall (Sept-Dec) August 15th
- Spring (Jan-May) November 15th
- Summer (Jun-Aug) April 15th

Volunteer applications, when complete, may be faxed or mailed to the address above. Upon receipt of a completed application, we will contact you within two weeks to acknowledge your application and inform you of current volunteer opportunities within the IHA. Thank you for striving to make a difference in the health care of our community!

Sincerely,
Sadie Hays
Clinic Coordinator
Ithaca Free Clinic



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Volunteer Application

~please print clearly~

Date _____

Full Name _____ Preferred Name _____

Address _____ City _____ State ____ Zip _____

Home _____ Work _____ Cell _____

Email _____ Birthday _____

Preferred method of contact Home Work Cell Email

Emergency Contact _____ Phone _____

- What other languages do you speak besides English?

- What skills would you like to contribute to the IHA (e.g. customer service, computer skills, etc.)?

- Why do you want to volunteer for the Ithaca Health Alliance?

- What would you like us to know about you (e.g. special needs, activity restrictions, career goals, etc.)?

Service Opportunities

<p>Licensed Medical Providers (<i>must have valid NYS license</i>)</p> <p><input type="checkbox"/> Certified Nurse Midwife</p> <p><input type="checkbox"/> Doctor of Chiropractic</p> <p><input type="checkbox"/> Doctor of Osteopathy</p> <p><input type="checkbox"/> Licensed Acupuncturist</p> <p><input type="checkbox"/> Licensed Massage Therapist</p> <p><input type="checkbox"/> Medical Doctor (specialty, if applicable: _____)</p> <p><input type="checkbox"/> Nurse Practitioner</p> <p><input type="checkbox"/> Occupational Therapist</p> <p><input type="checkbox"/> Physical Therapist</p> <p><input type="checkbox"/> Physician Assistant</p> <p><input type="checkbox"/> Registered Dietitian</p> <p><input type="checkbox"/> Registered Nurse</p> <p><input type="checkbox"/> Other _____</p>	<p>Administrative/Office</p> <p><input type="checkbox"/> Data Entry Clerk</p> <p><input type="checkbox"/> Office Support/ Administrative Assistant</p> <p><input type="checkbox"/> Patient Discharge Clerk</p> <p><input type="checkbox"/> Receptionist</p> <p><input type="checkbox"/> Reception Assistant</p> <p><input type="checkbox"/> Ithaca Health Fund Grant Assistant</p> <p><input type="checkbox"/> Computing and technical support</p> <hr/> <p>Outreach and Education</p> <p><input type="checkbox"/> Business Outreach</p> <p><input type="checkbox"/> IHA Member Provider Outreach</p> <p><input type="checkbox"/> IHA Member Services Assistant</p> <p><input type="checkbox"/> Event Coordination and Staffing (health-fairs, festivals, tabling)</p> <p><input type="checkbox"/> Health Education Programs</p> <p><input type="checkbox"/> Quarterly Newsletter</p> <p><input type="checkbox"/> Media & Graphic design</p>
<p>Certified Professionals (<i>provide certificates of education/ training</i>)</p> <p><input type="checkbox"/> Herbalist</p> <p><input type="checkbox"/> Naturopathic Doctor</p> <p><input type="checkbox"/> Reiki practitioner</p> <p><input type="checkbox"/> Yoga instructor</p> <p><input type="checkbox"/> Other _____</p>	<p>Leadership</p> <p><input type="checkbox"/> Financial management & oversight</p> <p><input type="checkbox"/> Grant-writing</p> <p><input type="checkbox"/> Community fundraising</p> <p><input type="checkbox"/> Clinical service planning</p> <p><input type="checkbox"/> Board of Directors: leadership and governance</p>

Availability

Please write hours avail.	Monday Clinic 2-6	Tuesday Clinic 3-7	Wednesday	Thursday Clinic 4-8	Friday	Sat/Sun outreach only
Morning (9-12)						
Afternoon (12-4)						
Evening (4-8)						

Frequency of Service? 1x/ month 2x/ month 1x/week 2x/week

Time Commitment? 3 months 6 months school year 1 year >1 year

Please use this space to describe other details regarding your availability (e.g. meeting every other Monday night, anticipated leave or travel, etc.)

Employment and Education

**Please attach your resume or professional CV*

Check applicable status: Employed Un-employed Retired Student

Employer _____ Occupation _____

Address _____ Phone _____

Current School _____ Expected Graduation _____

For Healthcare Providers only:

A. Licenses and Certifications

1) Type _____ Number _____ Expires _____

if applicable DEA Number _____ Expires _____

2) Type _____ Number _____ Expires _____

3) Other Certifications (CPR, BLS, ALS, PALS, etc) please list below

B. Malpractice Insurance

Do you currently have a malpractice insurance policy? Yes No

Carrier _____ Policy # _____

Limitations of coverage _____

Please attach a photocopy of documents **A and **B** above, as well as either letters from 3 references, or contact information for 3 references.*

Thank you for your application. We value your willingness to serve your community.
Upon receipt, an IHA staff person will contact you within two weeks.



ITHACA HEALTH ALLIANCE



Ithaca Free Clinic

CODE OF CONDUCT

- Shall apply to **all** volunteers and contractors involved with any aspect of the functioning, operations or committee activities of the Ithaca Health Alliance.
- All licensed health care practitioners shall practice within their **scope of practice**, as outlined in any applicable New York State licensing regulations. Any practitioner not bound by licensure shall practice according to applicable national standards set forth by any professional organizations relevant to their area of practice or expertise.
- **Patient and member confidentiality** shall be maintained at all times. No patient or member information shall be discussed in any public area. Any practitioner not directly involved in any given patient's care shall not access patient medical records, except when quality assurance activities may be assigned to that practitioner.
- In general, during actual clinic operations, no volunteer should be present in the Clinic unless **specifically assigned to work** that session. Exceptions may be made at the request of Alliance staff for the purpose of reviewing clinical operations and procedures.
- **No practitioner shall in any manner solicit patients** for his or her own private practice. Should a patient express interest in a given area of practice outside of or in addition to the Clinic setting, he or she shall be referred to the receptionist for a list of area clinicians and shall be asked to make private contact with the practitioner of his or her choice.
- **No practitioner shall promote** his or her expertise in the community in conjunction with his or her participation in the work of the Clinic, until and unless the manner and circumstances of such promotion have been approved by the Executive Director.
- All volunteers shall conduct themselves in a **professional and ethical manner** at all times and in any aspect of the Ithaca Health Alliance's operations or committee activities. All actions, verbal or written interactions and other behavior shall be such that the integrity of the Ithaca Health Alliance is maintained at all times and that such actions and behaviors **do not impede the process of the IHA toward achieving its goals and mission**. Concerns about operations, activities and/or personnel shall not

be discussed outside appropriate IHA/IFC committee activities. Professionalism shall also be applied to the dress code for all volunteers and/or contractors presenting in the clinical setting during business hours.

- The IHA Oversight Committee is responsible for **reviewing concerns** expressed by any volunteer, contractor or patient, for conflict resolution and for problem-solving and shall maintain the confidentiality and the dignity of any individual involved. This process shall include an impartial and objective review of any and all aspects of the concern involved.
- Should any volunteer have need of medical services and qualifies for a Clinic visit, he or she shall step out of their volunteer role and assume that of a patient and be **processed through the Clinic as would any other patient**, including registration, form completion and waiting their turn in the waiting room. No priority shall be given to any volunteer over other patients.
- **No criminal behavior (such as theft), discriminatory or prejudicial behavior, actions or speech shall be tolerated at any time.** Any such activity shall be cause for immediate suspension of the volunteer involved with follow-up and final recommendations to follow.

(Tear Off Here)



I, _____, have received a copy of
(Print Name)
the Ithaca Health Alliance **Code of Conduct**, and as a volunteer, and by my signature below, I agree that I have read, understand and agree to follow it.

Signature and Title (if appropriate)

Date

Date Filed in Personnel Record: _____