



#8157



Bethesda MAGAZINE  
"The Guide to Giving"



Dear Mobile Medical Care Volunteer Applicant,

We are pleased that you are interested in our volunteer program. Mobile Medical Care, Inc. (MobileMed) is a nonprofit organization whose mission is to improve the health of low-income people who face the greatest barriers to care access. We strive to be a primary care medical home – providing high quality, comprehensive healthcare, delivered in a respectful, competent, culturally sensitive and compassionate manner to those in need. To that end, we make every effort to insure consumer-friendly and responsive delivery systems that enhance patient independence and dignity, while minimizing patient stress, inconvenience and paperwork. We have 7 primary care clinics and 2 specialty clinics located throughout Montgomery County, as well as a main office in Bethesda.

In order to begin volunteering with MobileMed, we need you to first complete the General Support Volunteer Form. Completed applications can be mailed, e-mailed, or faxed to me, Matt Trebon, at the address listed below. If you fax the application, please attach a cover sheet and send it to my attention. Once we have received your application, we will contact you to complete your intake procedures and get you started on your new volunteer career.

Please feel free to contact me with any questions you may have. We hope that you will join the dedicated, skilled and enthusiastic cadre of volunteers at MobileMed. On behalf of our patients, we thank you for your time and attention.

Sincerely,

Matt Trebon  
Development Assistant  
Mobile Medical Care, Inc  
9309 Old Georgetown Rd.  
Bethesda MD 20814  
301-493-2400, ext 836  
Fax: 301-493-8553  
[mtrebon@mobilemedicalcare.org](mailto:mtrebon@mobilemedicalcare.org)



# General Support Volunteer Application

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ DOB: \_\_\_\_\_

How you first learn about volunteering with MobileMed?

\_\_\_\_\_

Why do you want to volunteer with MobileMed?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional services you can offer MobileMed** *(please indicate below)*

- |  |  |
|--|--|
| <input type="checkbox"/> Interpreter (language)<br>_____ | <input type="checkbox"/> Lawyer                      |
| <input type="checkbox"/> Office Assistant                | <input type="checkbox"/> Fundraising and Development |
| <input type="checkbox"/> Data Management                 | <input type="checkbox"/> Volunteer Support           |
| <input type="checkbox"/> Medical Records                 | <input type="checkbox"/> Facilities Repair/Handyman  |
| <input type="checkbox"/> Accountant                      | <input type="checkbox"/> Other _____                 |

Do you have any special needs that may require additional assistance?

\_\_\_\_\_

When are you prepared to start? \_\_\_\_\_

How long do you plan on volunteering? \_\_\_\_\_

**Period of Projected Availability** *(Please indicate below)*

- |                                    |                                    |                                     |
|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Monday    | <input type="checkbox"/> Morning   | <input type="checkbox"/> Weekly     |
| <input type="checkbox"/> Tuesday   | <input type="checkbox"/> Afternoon | <input type="checkbox"/> 1x Monthly |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> Evening   | <input type="checkbox"/> 2x Monthly |
| <input type="checkbox"/> Thursday  |                                    |                                     |
| <input type="checkbox"/> Friday    |                                    |                                     |

**Please check all areas that you available to volunteer**

*We will try to accommodate your location request but if those locations are not available, other location opportunities will be offered.*

- |  |                                    |                                       |
|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Silver Spring | <input type="checkbox"/> Rockville | <input type="checkbox"/> Gaithersburg |
| <input type="checkbox"/> Bethesda      | <input type="checkbox"/> Potomac   | <input type="checkbox"/> Germantown   |

**Emergency Contact Information**

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*If under the age of 18 a guardian's signature is required*

Guardian Name \_\_\_\_\_

Relationship to applicant \_\_\_\_\_

Contact number \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please submit a copy of your resume and appropriate certifications (if applicable)



# Confidentiality Agreement and Photo Release Form

Volunteer Name: \_\_\_\_\_

Address: \_\_\_\_\_

## Confidentiality Agreement

Recognizing the confidential nature of medical information and the provider patient privilege, which arises from communications between a patient and his/her provider, I hereby agree to maintain the absolute confidentiality of any medical information pertaining to a patient, which I obtain during my volunteerism at Mobile Medical Care, Inc. I hereby acknowledge that I understand that medical information pertaining to a patient may not be revealed without the express written permission of the patient or as otherwise permitted by the law.

Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor \_\_\_\_\_ Date \_\_\_\_\_

## Photography Release Agreement

I hereby grant to Mobile Medical Care, Inc. the irrevocable and unrestricted right to use and publish photographs of me, or in which I may be included, for publications, electronic reproductions (websites) and/or promotional materials or any other purpose and in any manner or medium. In addition, I grant my permission to alter the same without restriction; and to copyright the same. I hereby release the photographer and Mobile Medical Care, Inc. from all claims and liability relating to said photographs.

Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_



## Montgomery County Government

### Confidentiality Agreement

I understand that in the performance of my duties as a volunteer for Montgomery County Government, I may have access to confidential information. I understand that any violation of the confidentiality of this information may result in my dismissal or possible legal action taken against me.

\_\_\_\_\_  
Volunteer signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Volunteer Coordinator signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mobile Medical Care  
Department