MobileMed
Mobile Medical Care, Inc.

PROUD MEMBER OF United Way
United Way of the National Capital Area
#8157

Bethesda MAGAZINE
"The Guide to Giving"

GuideStar Exchange GOLD PARTICIPANT

Dear Mobile Medical Care Volunteer Applicant,

We are excited that you have shown interest 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 provide primary and preventive services to low-income adults residents of Montgomery County. MobileMed believes that free or low-cost medical care can and should be delivered in a respectful, competent, and compassionate manner to those in need. To that end, we make every effort to ensure patient-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 care clinics located throughout Montgomery County, including our main office in Bethesda.

In order to commence volunteering with MobileMed, you must first complete the Clinical Support Volunteer Application. Completed applications, with original signatures, can be mailed to Jessica Gebhard at the address listed below or emailed to jgebhard@mobilemedicalcare.org. Jessica's phone number is (301)493-2400, ext. 839. If you would like to fax the application, please send it to 1301-493-8553, along with a cover sheet sent it to the attention of Jessica Gebhard.

Once we have received your application, we will contact you to complete in-take 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,

Peter F. Lowet

Peter F. Lowet
Executive Director
9309 Old Georgetown Road
Bethesda, MD 20814

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Clinical 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 Mobile Medical Care?

_____

Why do you want to volunteer with Mobile Medical Care?

_____
_____
_____
_____
_____
_____

Services you can offer Mobile Medical Care (*please indicate below*)

- ☐ Physician
- ☐ Nurse Practitioner
- ☐ Physician Assistant
- ☐ Registered Nurse
- ☐ Registered Dietitian
- ☐ Licensed Practical Nurse
- ☐ Medical Assistant
- ☐ Pharmacist
- ☐ Diabetic Educator
- ☐ Interpreter (language) _____
- ☐ Data Management
- ☐ 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*)

☐ Monday ☐	☐ Morning	☐ Weekly
Tuesday	☐ Afternoon	☐ 1x Monthly
☐ Wednesday	☐ Evening	☐ 2x Monthly
☐ Thursday		
☐ Friday		

Please check all areas that you available to volunteer? *We will try to accommodate your location requests, but if those locations are not available other location opportunities will be offered*

☐ Silver Spring	☐ Rockville	☐ Gaithersburg ☐ Germantown
☐ Bethesda	☐ Potomac	

Emergency Contact Information

Name: _____	Name: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Address: _____	Address: _____
_____	_____

Signature_____ Date _____

Please submit a copy of your:

- **Curriculum Vitae**
- **Any Applicable Board Certifications**
- **CPR Certification**

Providers (Physicians)

Are you currently licensed in Maryland? ☐ Yes ☐ No

License Number: _____ ☐ Active ☐ Inactive

Exp. Date: _____

Are you licensed in another jurisdiction? ☐ Yes ☐ No

If Yes, where? _____

License Number: _____ Specialty: _____

Do you have a current DEA Number? ☐ Yes ☐ No

DEA Number: _____ Expiration: _____

NPI#: _____

Current Malpractice Insurance? ☐ Yes ☐ No

Name of Certifying Board: _____

Specialty certified in: _____

Original year of certification: _____

Renewal date (if applicable): _____

Expiration date (if applicable): _____

Fellowship Training (if applicable)

Name of professional school attended: _____

Specialty of Program: _____

Dates of Program: _____ Date of Completion: _____

Address (city, state, zip):_____

Internship, Residency Training

Name of professional school attended: _____

Specialty of Program: _____

Dates of Program: _____ Date of Completion: _____

Address (city, state, zip):_____

Medical School of Professional School

Name of Institution: _____

Address (city, state, zip):_____

Degree: _____ Date of Graduation: _____

Providers (Nurse Practitioners and Physician Assistants)

Are you currently licensed in Maryland? ☐ Yes ☐ No

License Number: _____ ☐ Active ☐ Inactive

Exp. Date: _____

Are you licensed in another jurisdiction? ☐ Yes ☐ No

If Yes, where? _____

License Number: _____

Specialty: _____

Do you have a current DEA Number? ☐ Yes ☐ No

DEA Number: _____ Expiration: _____

NPI#: _____

Current Malpractice? ☐ Yes ☐ No

Nurses and Medical Assistants

☐ RN

☐ LPN

☐ CNA

☐ MA

☐ Adult

☐ Family

☐ Pediatric

☐ Other_____

Are you currently licensed in Maryland? ☐ Yes ☐ No

License Number: _____ ☐ Active ☐ Inactive

Exp. Date: _____

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Medical Information, Confidentiality Agreement, Photo Release Form

Volunteer Name: _____

CLINICAL VOLUNTEERS in medical settings in Montgomery County are required to have the following **testing and immunization:**

- ❑ Hepatitis B Vaccine/Hepatitis B Surface Antibody titer result/signed waiver*
- ❑ PPD (TB Mantoux)

Volunteer Signature _____ Date _____

In signing this form the above named volunteer acknowledges previously receiving the complete Hepatitis B Vaccine series or having had a Hepatitis B Surface Antibody titer within the last 12 months. The volunteer also acknowledges that PPD testing has been within last 12 months.

*see additional form for signed waiver of Hep B vaccine

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 employment/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 (web sites) 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_____

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Informed Refusal for Hepatitis B Vaccination (HBV)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious material and I want to be vaccinated with hepatitis B vaccine, my employer will provide this vaccination series at no charge to me.

Employee's Signature _____ Date_____

Witness to Signature _____ Date _____

Name **(Print or Type) _____**

Address (number, street, apt.) _____

City _____ State ____ Zip _____

Maintain this record for duration of employment, plus 30 years **Confidential**

Updated Apr. 2011

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RELEASE & ATTESTATION

In making medical application for membership to the medical staff, I hereby authorize Mobile Medical Care, Inc. and its credentialing verification organization, CHG Companies, Inc. (dba CompHealth Credentialing), its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications including information about disciplinary actions or other confidential or privileges information, and other credentials.

I authorize the release of all information necessary from all medical schools, colleges, universities, transcript offices, medical institutions, or other organizations, hospital, employers, personal references, physicians, attorneys, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner Data Bank, the Federation of State medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, specialty boards and any other pertinent source.

I hereby indemnify and hold harmless Mobile Medical Care, Inc. and CHG Companies, Inc., their agents, officers and employees, as well as any third parties, including, but not limited to, the Federation of State Medical Boards and the others listed above, from any damages or liability, civil or otherwise, from any acts performed in good faith without malice and in connection with the collection and verification of such information.

I understand that I have the burden of providing adequate information to Mobile Medical Care, Inc. and CHG Companies, Inc. its affiliates or successors, to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial or summary dismissal as a participating provider. If any material changes occur affecting my professional status, it is my obligation to notify Mobile Medical Care, Inc., and CHG Companies, Inc., or the appropriate affiliate or successor as soon as possible.

I attest that information that is contained in this application is correct and complete.

A copy of this document shall operate as full proof of authority and release.

Name _____

Social Security Number _____

Date of Birth _____

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

9309 Old Georgetown Road Bethesda, MD 20814 301.493.2400 www.mobilemedicalcare.org

Montgomery County Government

Volunteer Acknowledgement of Risk

I acknowledge the volunteer work I agree to perform may involve risk of personal injury or death; however, I agree to perform the duties assigned to me, and I accept responsibility for my personal safety.

_____ _____

Volunteer Signature Date

_____ _____

Volunteer Coordinator Signature Date

Mobile Medical Care_____

Department

9309 Old Georgetown Road Bethesda, MD 20814 301.493.2400 www.mobilemedicalcare.org

MONTGOMERY COUNTY POLICY ON SEXUAL HARASSMENT

PURPOSE

To state the County's policy on sexual harassment and provide a procedure for the handling of sexual harassment complaints.

I, _____
Acknowledge receiving a copy of the Montgomery County's Sexual Harassment Policy.

Social security number

Date of birth

Signature Date

PLEASE SIGN THE ABOVE MONTGOMERY COUNTY POLICY ON SEXUAL HARASSMENT.

THE FOLLOWING DOCUMENT WHICH CONSISTS OF THE

MONTGOMERY COUNTY POLICY ON SEXUAL HARASSMENT SHOULD BE REMOVED AND KEPT FOR YOUR PERSONAL RECORDS.

MONTGOMERY COUNTY POLICY ON SEXUAL HARASSMENT

****Please read document and sign & return only the previous page with your application****

PURPOSE

To state the County's policy on sexual harassment and provide a procedure for the handling of sexual harassment complaints.

DEFINITION

Sexual harassment is verbal or physical conduct that includes:

1. unwelcome sexual advances;
2. requests for physical conduct of a sexual nature; and
3. any written, verbal or physical conduct of a sexual nature when:
    a) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
    b) submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual; or
    c) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

In the context of items 1-3 above, sexual harassment includes, but is not limited to: requests for sexual favors; the use of threats or force to obtain sexual favors; sexual propositions or innuendo; suggestive comments; sexually-oriented teasing or joking; jokes about gender-specific traits; unwelcome or uninvited touching, patting, pinching or brushing against another's body; obscene spoken or written language; obscene gestures; and display of offensive or obscene printed or visual material.

POLICY

1. Every employee has the right to work in an environment free of all forms of discrimination. Sexual harassment is a form of discrimination that is illegal under federal, state and local laws and will not be tolerated.

2. County employees must not subject other employees, contractors, consultants, citizens, applicants, customers or clients to sexual harassment. An employee who is found to have engaged in sexual harassment will be subject to appropriate disciplinary action, which may include dismissal.

3. Managers and supervisors must ensure that employees under their supervision or direction are provided a work environment free of sexual harassment.

Managers and supervisors who become aware of suspected or reported sexual harassment must promptly report the information to the Department or Office Head, to the EEO Officer in the Office of Human Resources, or to an attorney in the Office of the County Attorney.

4. This policy applies to County employees when they are conducting County business and dealing with others while at work or at work-related social functions.

5. Any employee who witnesses sexual harassment must report this conduct to the Department or Office Head, to the EEO Officer in the Office of Human Resources or to an attorney in the Office of the County Attorney.

6. The sexual harassment of County employees by contractors, consultants subcontractors, their employees, individuals who conduct business with the County, or individuals who receive services from the County will not be tolerated, and may result in termination or suspension of the contract, denial of contracting privileges, denial of services, or the filing of criminal charges against the harasser.

7. The use of threats or other means to retaliate against another who resists harassment, reports the alleged harassment to another, participates or cooperates in an investigation of a complaint of sexual harassment or files a complaint about the alleged harassment is prohibited.

8. Advice and counseling concerning sexual harassment may be obtained from a number of sources including: the County Attorney, Office of Human Resources, Union representatives and the Montgomery County Commission for Women.

PROCEDURE

1. Filing and Investigation of Complaints

a) An employee who is subjected to sexual harassment, witnesses it, or has knowledge of it should immediately bring the matter to the attention of his or her supervisor. If the supervisor is a party to the harassment, or if the employee does not wish to discuss the matter with the supervisor, the employee must bring it to the attention of the Department or Office Head, to the EEO Officer in the Office of Human Resources, or to an attorney in the Office of the County Attorney.

b) A person who is the recipient of a complaint must document information relevant to the complaint, including the date and substance of the complaint and the names of individuals who were involved or who witnessed the incident(s). The recipient must notify the EEO Officer in the Office of Human Resources or an attorney in the County Attorney's Office within 24 hours. The recipient may refer the complaint to the EEO Officer for investigation or, if the EEO Officer and the County Attorney concur, may investigate the complaint and attempt to resolve it informally. Informal resolution is appropriate only if the essential facts of the complaint are undisputed and both the victim and alleged perpetrator of the harassment agree to informal resolution. If attempts at informal resolution are unsuccessful, the complain must be referred to the EEO Officer or an attorney in the County Attorney's Office within three (3) working days.

c) A complaint brought to the attention of the EEO Officer or an attorney in the County Attorney's Office may be oral or written and may be brought by any person having knowledge of the harassment.

d) The EEO Officer or an attorney in the County Attorney's office will initiate the investigation of a complaint within 24 hours after the allegation is brought to his or her attention or notice is received that an attempt at informal resolution has been unsuccessful.

e) Every effort will be made to maintain the confidentiality of the information provided in connection with a sexual harassment complaint, and to protect the privacy of the individuals involved. Information about the investigation will be given only to those persons who have a genuine need for the information because of their role in the investigation or those who are legally entitled to the information. Anonymity or confidentiality cannot be guaranteed.

f) To the extent possible, the investigation and attempts to resolve the complaint will be completed within fourteen (14) working days of the filing date of the complaint.

g) Promptly upon completing the investigation, the EEO Officer or an attorney in the County Attorney's Office will notify the alleged victim, alleged perpetrator, and appropriate management officials of the results of the investigation and the recommendation for resolution.

2. **Remedial Action**

a) If the alleged perpetrator is a County employee, the Director of the Department or Office where the alleged perpetrator is employed is responsible for taking appropriate remedial action to resolve the complaint. Appropriate remedial action may include referral to the Employee Assistance Program or other type of counseling, transfer, disciplinary action, including discharge, or the filing of civil criminal charges.

b) If the alleged victim is a County employee, but the alleged perpetrator is a contractor, consultant, subcontractor, their employees, individuals who conduct business with the County, or individual who receive services from the County, the appropriate remedial action will be recommended by the County Attorney and implemented by the CAO.

c) The EEO Officer will continue to review the complaint until the complaint is resolved and report the status of the complaint and investigation to the County Attorney on a regular basis as agreed by the EEO Officer and the County Attorney.

EDUCATION AND TRAINING

1. The County will provide ongoing educational and training programs to inform employees about sexual harassment, how to prevent it and how to identify and deal with complaints of sexual harassment.
2. This policy must be provided to all employees and must be made available to the public.
3. Further information about this policy or how to file a complaint may be obtained by contacting the EEO Officer in the Office of Human Resources.

EFFECTIVE DATE

This policy is effective immediately upon the signature of the County Executive below.

Approved:

Signed by Douglas M. Duncan — 8/1/96
Douglas M. Duncan — Date
County Executive

Approved for form and legality:

Signed by Charles W. Thompson — 7/31/96
Charles W. Thompson, Jr. — Date
County Attorney

Computer and Information Usage Agreement

Mobile Medical Care, Inc. considers maintaining the security and confidentiality of protected health information (PHI) a matter of its highest priority. All those granted access to this information must agree to the standards set forth in this Computer and Information Usage Agreement. All those who cannot agree to these terms will be denied access to PHI entrusted by our patients to this organization. Each person accessing Mobile Medical Care, Inc. data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. The following conditions apply to all those having access to protected health information.

I will:

- Respect the privacy and rules governing the use of any information accessible through the computer system or network and only utilize information necessary for performance of my job.

- Respect the ownership of proprietary software. For example, do not make unauthorized copies of such software for your own use, even when the software is not physically protected against copying.

- Respect the finite capability of the systems, and limit use (such as executing, during normally peak periods of usage, programs that consume significant computer resources) so as not to interfere unreasonably with the activity of other users.

- Respect the procedures established to manage the use of the system.

- Prevent unauthorized use of any information in files maintained, stored, or processed by Mobile Medical Care, Inc.

- Not seek personal benefit or permit others to benefit personally by any confidential information or use of equipment available through my work assignment.

- Not operate any non-licensed software on any computer provided by Mobile Medical Care, Inc.

- Not exhibit or divulge the contents of any record or report except to fulfill a work assignment and in accordance with Mobile Medical Care, Inc. policy.

- Not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.

- Not remove PHI from the office where it is kept except in the performance of my duties.

- Understand that the information accessed through all Mobile Medical Care, Inc._information systems contains sensitive and confidential patient care, business, financial and employee information, which should only be disclosed to those authorized to receive it.

- Not release my authentication code or device to anyone else, or allow anyone else to access or alter information under my identity.

- Not utilize anyone else's authentication code or device in order to access any Mobile Medical Care, Inc.'s system.

- Respect the confidentiality of any reports printed from any information system containing patient information and handle, store and dispose of these reports appropriately.

- Not divulge any information that identifies PHI.

- Understand that all access to the system will be monitored.

I understand that my access to PHI maintained by Mobile Medical Care, Inc. is a privilege and not a right afforded to me. By signing this agreement, I agree to protect the security of this information and maintain all PHI in a manner consistent with the requirements outlined under applicable Federal and State privacy laws and regulations.

Mobile Medical Care, Inc. agrees to hold me harmless with regard to my access to PHI maintained by Mobile Medical Care provided that I use due diligence in meeting the terms of this Computer and Information Usage Agreement.

_____
Name (print)

_____
Name (signature)/Date

_____
Title