



## **Thank you for your interest in volunteering at Grace Clinic!**

Grace Clinic is entirely a community supported organization. All of our volunteers & funding come from our community. Many people come together to help meet the needs of low income, uninsured residents. Since the Clinic began operations in 2002, we have provided 70,000+ patient visits.

We hold an orientation and information session which is typically on the first Thursday of each month at 6:30 PM at the Clinic. Please call the Clinic at 509-735-2300 to confirm the date and please plan to join us to learn more about the Clinic and the facility.

The volunteer application can be completed online through our website at [www.GraceClinicOnline.org](http://www.GraceClinicOnline.org). Paper copies are also available. In addition to the application, the following documents must be completed before you begin serving at the Clinic. The Statement of Faith is optional and is not required to be completed by all volunteers.

Thank you again for your interest in serving others in our community, and we look forward to working with you.

Mark C. Brault, CEO



## Ethical Statement

GRACE CLINIC considers every life to be a gift of God to be used according to His standards and for His purpose. *Therefore ~*

THIS CLINIC is provided for the benefit of those individuals who lack the resources to obtain medical care through other means. Thus, individuals with medical insurance or other medical coverage may be directed to their providers, so those without coverage can get the care they may need.

GRACE CLINIC will not promote or condone any form of suicide [doctor assisted or otherwise] or euthanasia, or any form of abortion. Any women needing pregnancy counseling will be referred to the You Medical (formerly Tri-Cities Pregnancy Network) or Hope Medical of Washington.

GRACE CLINIC will promote abstinence as the God-appointed form of birth control for single people, and will direct persons to other available community resources for birth control.

GRACE CLINIC considers the proper stewardship of the body to be one of God's requirements and therefore will not participate in any project or program that would condone or prolong drug abuse, such as needle exchange programs. The stewardship principle also compels us to encourage our patients to stop any drug, tobacco, or alcohol abuse and encourages us, as volunteers, to serve as examples in this area.

*I have read the above Ethical Statement of Grace Clinic and will uphold these policies while working at the clinic as a volunteer.*

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



## Statement of Faith

We Believe:

- That the Bible is the inspired word of God.
- That there is one God, eternally existent in three persons: God the Father, God the Son, and God the Holy Spirit.
- That Jesus Christ is the only Son of God, He was born of the Virgin Mary, He lived a sinless life, and He was crucified for our sins and rose again.
- That the most important thing in the entire world is a personal relationship with Jesus Christ through faith in Him.
- That a relationship with Christ comes only through God's grace not by man's effort.
- That the Holy Spirit is living within the believer enabling him to live the Christian life.
- That we should share the love of Jesus Christ with our patients and community as the Holy Spirit leads and provides opportunity.

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

*\*Signature is required for Team Leaders, Spiritual Care, Staff, and Board Members.  
It is optional for other volunteer positions.*



## Confidentiality Statement

We treat the confidentiality of patient and volunteer information seriously.

All patient Protected Health Information, which includes patient medical and financial information, all financial and operational data of Grace Clinic, and any other information of a private or sensitive nature, is considered confidential. Confidential information shall not be used or disclosed unless specific permission to do so has been obtained and granted by designee. Applicable federal and state laws shall be followed to seek patient permission for any use or disclosure of Protected Health Information. Examples of inappropriate disclosures include:

- Discussing or revealing confidential information to friends or family members.
- Discussing or revealing confidential information to other volunteers at Grace Clinic without a legitimate need to know.
- The disclosure of a patient's presence in the office, clinic or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know and that may indicate the nature of the illness and jeopardize confidentiality.
- Using patient information for marketing purposes without express permission from Grace Clinic and the patient.

## Confidentiality Agreement

I understand that patient Protected Health Information and other proprietary information of Grace Clinic which I may see or hear or otherwise gain knowledge of in the course of my work with Grace Clinic is to be kept confidential. I agree to keep all of this information confidential and shall not use it or disclose it to anyone unless specifically authorized by Grace Clinic to do so.

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

Print Name \_\_\_\_\_

DISCLOSURE STATEMENT

PURSUANT TO THE REQUIREMENTS OF 1987 WASHINGTON LAWS CHARTER 486, WE MUST ASK YOU TO COMPLETE THE FOLLOWING DISCLOSURE STATEMENT. THIS INFORMATION WILL BE KEPT CONFIDENTIAL. (RCW43.43.830 THRU 845)

Have you ever been convicted of any of the following crimes against persons or crimes of financial exploitation:

Form with columns for Yes/No and a list of crimes including Aggravated Murder, Arson, Assault, Burglary, Child Abuse, etc.

If you answered "YES" to any of the above questions, please describe and provide date(s) of the conviction(s) and the sentence(s) imposed. Use separate sheet of paper if necessary.

Three horizontal lines for providing details of convictions.

I understand that if any of the information provided above is found to be false, it may result in the loss of my employment.

This document is signed and sworn to under penalty of perjury. I certify that the above information is true and correct. My signature below authorizes Grace Clinic to obtain conviction records from the Washington State Patrol and other states, to release the result to the facility or person named above, and if I am a nursing assistant, to the Omnibus Budget Reconciliation Act (OBRA) Nurse Assistant Registry.

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

Name (print): \_\_\_\_\_