Roger Bouck RotaCare Clinic - Lake City

(Please type or print all information clearly)

Volunteer Application

First Name: _____ Middle: _____ Last: _____

Address: _____ City: _____ State _____ ZIP _____

Phones Home: _____ Cell: _____ E-Mail: _____

Date of Birth: _____ Social Security # _____

WA Professional License #: _____

Mds: Medical School _____ Grad. Yr: _____

Specialties _____

Employed: Yes ☐ No ☐ Employer: _____ Work Phone: _____

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In what capacity do you wish to volunteer Physician ☐ Nurse Practitioner ☐ Nurse ☐ Physician's Assistant ☐

Dentist ☐ Dental Hygienist ☐ Dental Assistant ☐ Student ☐ Other ☐ Describe: _____

Social Worker ☐ Registration ☐ Scheduling ☐ Pharmacy ☐ CMA ☐ Interpreter ☐ Clerical ☐ .

Do you speak another language? Yes ☐ No ☐ Language's _____

List any other special skills or talents? _____

I am available to volunteer (**circle**) Weekly ☐ Twice Monthly ☐ Monthly ☐ Quarterly ☐ Other ☐

For Dentists: Pro-Bono, number of patients per month: _____ Specialty: _____

Notes or Comments: _____

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Hold Harmless Agreement: I understand that I am a volunteer for *RotaCare* and have accepted this position of my own free will. Furthermore, I agree to hold the corporation, it's officers, employees and other volunteers harmless in any dispute that might arise over any incident occurring in the clinic or while I am acting on behalf of RotaCare and any of it's subsidiaries.

Confidentiality Acknowledgement: I understand that any information, including patient names and status, which is disclosed to me while I am visiting, participating in, or assisting in a *RotaCare* Clinic, or while I am processing paperwork for *RotaCare* is confidential and protected by federal law. Federal regulation (42 CFR Part 2) prohibits me from making any disclosure or release of such information without the written consent of *RotaCare* and the person to whom the information pertains.

The applicant's signature indicates that applicant agrees to abide by the above and all rules and regulations of RotaCare.

Signature _____ **Date** _____

Please send completed application with a copy of your professional license or registration/certification to:

RotaCare Credentialing, Attn: Bob Gotshall 15540 Beach Dr NE, Lake Forest Park, WA 98155 (rgotshall7@msn.com)

Then email Mary Starkebaum that you have sent in your application.

Dr. Mary Starkebaum - Medical Dir. Home (206) 440-0777 Cell (206) 890-9290 Email: **marystarkebaum@comcast.net**

(for RotaCare Use only)
Staffing Committee Approval: _____ Date: _____
(Medical Director)