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Dear Friend,

The mission of the North by Northeast Community Health Center is to improve health outcomes in a medically under-served community by offering health screening and basic medical services at no cost. Priority is given to low-income uninsured adults living in the surrounding North and inner Northeast Portland neighborhoods.

Thank you for your interest in volunteering with us. Care at the North by Northeast Community Health Center is provided entirely by volunteers, and we have a variety of opportunities available for individuals with both clinical and non-clinical skills and interests.

Following are the documents needed to continue your application process, as well as a brief description of the volunteer position for which you are applying. The information you provide here will be used to assess your fit with current open positions.

You may return your completed application by email, fax, or regular mail to:

North by Northeast Community Health Center  
3030 NE Martin Luther King, Jr. Blvd.  
Portland, OR 97212  
503-287-4932 (phone)  
503-287-7480 (fax)  
sbutcher@nxneclinic.org

Please feel free to give me a call with any additional questions.

Sincerely,

Sharetta Butcher  
Office & Volunteer Coordinator

## Nurse Duties

### Pre-clinic duties

- Sign in on the Volunteer Hours Log
- Review Communication Log.
- Ensure rooms are ready for patients.
- Begin triage of patients as soon as possible.

### Clinic duties

- Respond to medical emergencies, as needed. Notify clinician of unstable patients as soon as identified.
- Triage each patient to determine if clinician visit is needed. Those with needs that can be addressed without clinician visits (e.g. BP checks) need a non-clinician encounter note written, including an appropriate disposition.
- Room the patients needing clinician visits and complete the top section of the progress note. **Keeping rooms filled with patients at all times is the key to providing services to the greatest number of patients per clinic.**
- Administer immunizations as requested by clinicians.

### Before leaving

- Ensure that the clinic is clean and rooms ready for the next clinic.
- Ensure that any significant follow up issues are documented in the communication log.
- Sign out on the Volunteer Hours Log.
- Sign up for your next shift on the Volunteer Schedules!

### **Application Check List**

Thank you very much for your interest in volunteering at the North by Northeast Community Health Center. We've included several items for your review.

Please return the following to us to complete the application process:

- North by Northeast application, completed & signed
- Code of Ethics and Expectations, signed
- Multnomah County Health Department application, completed & signed

These items will be kept in our confidential Personnel File at NxNE.

### **Timeline**

Upon receipt of your application, we will assess the best fit for you within our current open positions and according to your interests. We will then verify your employment, speak with your personal reference and contact you to set up an interview.

Once we have decided to approve you as a volunteer, we will set up a shadow shift. At that time, you will receive a volunteer orientation packet, and any further orientation needed will be arranged before you begin to work.

Please call us or contact us by email if you have any questions. Your time and talent are greatly appreciated and will help make a difference in the health of the patients we serve, as well as the surrounding community.

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**CERTIFIED MEDICAL ASSISTANT: APPLICATION FOR VOLUNTEERING**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Personal reference: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of current employment: \_\_\_\_\_

Work address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Work phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Name of supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

1: I am interested in working at North by Northeast Community Health Center because:

2: I give permission for NxNE to contact my employer to verify that I am an employee in good standing. YES or NO

3: I give permission for NxNE to contact my personal reference. YES or NO

4: I understand that before I can begin volunteering at NxNE I will need to review the policies and procedures relevant to my position and agree to abide by them. YES or NO

5: I understand no malpractice coverage is provided by NxNE, but that indemnification is provided by Multnomah County through the Coalition of Community Health Clinics. YES or NO

6: I have completed HIPAA training through my place of employment. YES or NO

7: I have had TB screening through my place of employment within the last year. YES or NO

8: I have had hepatitis B vaccination. YES or NO

9: I have read and agree to abide by the attached NxNE Clinic Policy on Infectious Materials.  
YES or NO

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

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

Reviewed by: \_\_\_\_\_

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

### Mission Statement

Our mission is to improve health outcomes in the medically under-served N/NE Portland community by offering health screening and basic medical services to adults at no cost. Priority is given to low-income neighborhood residents without health coverage.

### Code of Ethics and Expectations

As a clinic volunteer or employee, I agree to:

- Keep confidential all information I may learn directly or indirectly about a patient, employee or volunteer unless legally obligated to do otherwise. I will only seek information on a client that is important to the performance of my assigned tasks.
- Treat all patients, staff and volunteers with dignity, courtesy and respect.
- Embrace the diversity of patients, staff and volunteers, regardless of cultural or language differences, economic status, physical handicap, sexual orientation or religious affiliation.
- Arrive on time for my scheduled shift or notify the clinic manager as soon as possible if I am unable to keep my commitment to work or volunteer as scheduled.
- Bring an attitude of open-mindedness and willingness for training and supervision.
- Complete all tasks with a commitment to quality.
- Present a professional and caring image and demeanor to patients, staff and volunteers.
- Discuss any problems, issues or suggestions with the clinic manager or medical director.
- Adhere to the clinic policies and guidelines.

As a clinic volunteer or employee, I further agree to:

- Notify NxNE staff of any change in identifying or contact information.
- Notify NxNE staff of any change in licensing status (for licensed volunteers only).
- Report to NxNE staff any issues noted that could lead to poor patient care, either medical or behavioral.

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

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

Print name: \_\_\_\_\_

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## Policy Statement

Potentially infectious materials must be handled with caution to decrease the risk to staff and patients at NxNE. "Universal Precautions" guidelines will be followed.

## Procedure

1. All human blood is to be treated as if it is infectious for HIV and HBV. Universal precautions do not apply to feces, nasal secretions, sputum, tears, sweat, urine or vomit unless they contain visible blood.
2. NxNE will have gloves, pocket masks and CPR masks available. Gloves will be worn when any body fluid exposure is likely.
3. Clean-up of body fluids procedure will include:
  - a. Gloves are to be worn at all times and disposed of in bagged garbage containers. Hands are to be washed after gloves are removed.
  - b. Paper towels or blue pads will be used to absorb large volumes with immediate bagging and disposal in the trash.
  - c. Liquids in containers may be disposed of in the toilet. The containers will then be disposed of in bagged garbage containers.
  - d. Once the majority of the spill is absorbed, soap and water cleaning will occur, if needed.
  - e. Finally, a bleach solution will be used to decontaminate the surface.
4. Clean-up of spills on the carpet will follow the above procedure with the use of spray carpet cleaner instead of soap and water and bleach solution. If the spill is significant in volume or includes blood, the clinic manager must be notified. The carpet will need to be cleaned using a carpet-cleaning machine.
5. Bleach solution will be made as needed, for clean-up of human blood, and the bottle labeled with the date. 10% bleach is effective in decontamination according to the CDC. Data show bleach solutions lose about 60% of the concentration of available chlorine 30 days after being made, so the initial concentration of bleach

will be a 25% solution (1 part bleach to 3 parts water). The solution will be discarded after 30 days.

6. Disinfecting cleaning wipes will be used to clean the examination tables after use by patients who have been disrobed from the waist down and at the end of each clinic.
7. Paper products, urine test strips, strep tests, tissues and other non-saturated waste will be disposed of in bagged garbage containers. (Saturated is defined as dripping when picked up.)
8. Sharps will be disposed of in sharps containers (red, labeled, rigid, leak-proof and puncture resistant) kept at the site of the sharps use. The containers will be disposed of when the containers are  $\frac{3}{4}$  full. The container will be closed tightly and taped shut before disposal. Sharps containers will be disposed of according to the requirements of Portland Metropolitan waste services.

#### References:

"Infectious Waste Disposal: Questions and Answers." DHS/Oregon Health Services Office of Disease Prevention and Epidemiology: Acute and Communicable Disease Prevention. July 2006. Accessed at <http://www.oregon.gov/DHS/ph/acd/infectwaste/infect1.pdf>.

Rutala, W. A. and D. J. Weber. "Uses of Inorganic Hypochlorite (Bleach) in Health-Care Facilities." *Clinical Microbiology Reviews* 10 (1997): 597-610.



**MULTNOMAH COUNTY**  
**HEALTH DEPARTMENT**  
Volunteer Health Care Provider Indemnification

**VOLUNTEER HEALTH CARE PROVIDER APPLICATION**

**DEMOGRAPHICS:**

Name in Full: \_\_\_\_\_

Workplace: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

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

Work E-mail: \_\_\_\_\_

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

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

Home E-mail: \_\_\_\_\_

Where do you prefer to receive mail?  home  work

Where do you prefer to receive phone calls?  home  work

Where do you prefer to receive e-mails?  home  work

**EDUCATION:**

College/University: \_\_\_\_\_ Yr. Grad: \_\_\_\_\_ Degree: \_\_\_\_\_

Professional School: \_\_\_\_\_ Yr. Grad: \_\_\_\_\_ Degree: \_\_\_\_\_

Post Graduate Training: \_\_\_\_\_ Dates: \_\_\_\_\_

Foreign Language proficiency: Language \_\_\_\_\_

Primary (native) language  Beginner  Intermediate  Fluent (as a 2<sup>nd</sup> language)  Non-Applicable

**LICENSURE:**

Board: \_\_\_\_\_ State: \_\_\_\_\_ Lic # \_\_\_\_\_ Issue Date: \_\_\_\_\_

DEA Registration: \_\_\_\_\_ I have not applied for my own DEA Registration Certificate.

\_\_\_\_\_ I have applied for, but have not yet obtained, my own DEA Registration Certificate.

\_\_\_\_\_ My DEA Registration # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

\_\_\_\_\_ Not Applicable/Other: \_\_\_\_\_

Board Certification  Yes  No Specialty \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Are you currently credentialed through Multnomah County Health Department or CareOregon?**

Yes  No

***Enclose a copy of your license, DEA registration and Board Certificate(s).  
Return completed application to your recruiting clinic.***

<b>ATTESTATION QUESTIONS – This section to be completed by the Practitioner.</b> <b>Modification to the wording or format of these Attestation Questions will invalidate the application.</b>		
Please answer the following question “yes” or “no”. If your answer to any of the following questions is “yes”, please provide details and reasons, as specified in each question, on a separate sheet. <b>Please sign and date each additional sheet.</b>		
1.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certification in any jurisdiction <b>ever been</b> denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you <b>ever been</b> fined or received a letter of reprimand or is any such action pending or under review?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you <b>ever been</b> suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Have you <b>ever been</b> denied clinical privileges, membership, contractual participation or employment by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization <b>ever been</b> placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you <b>ever</b> surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* <b>ever been</b> withdrawn on your request prior to the organizations final action?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization <b>ever been</b> revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES <input type="checkbox"/> NO <input type="checkbox"/>
7.	Have you <b>ever</b> had board certification revoked?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8.	Have you <b>ever been</b> the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
9.	Have you <b>ever been</b> charged with a criminal violation (felony or misdemeanor)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
10.	Do you presently use any illegal drugs?	YES <input type="checkbox"/> NO <input type="checkbox"/>
11.	Do you now have, or have you recently had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested?  If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES <input type="checkbox"/> NO <input type="checkbox"/>
12.	Are you <b>unable</b> to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES <input type="checkbox"/> NO <input type="checkbox"/>
13.	Have any professional liability claims or lawsuits <b>ever been</b> files against you? If yes, please complete <b>Attachment A</b> for <b>each</b> past or current claim and/or lawsuit.	YES <input type="checkbox"/> NO <input type="checkbox"/>
14.	Has your professional liability insurance <b>ever been</b> terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you <b>ever been</b> denied professional liability insurance?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>* e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system</b>		
I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.		
I agree to provide care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.		
<b>Signature:</b> _____		<b>Date:</b> _____

**OSHA TRAINING & IMMUNIZATIONS:** Volunteers are subject to OSHA regulations. OSHA requires yearly attendance at blood borne pathogens training, Hepatitis B vaccination, and an annual PPD test. Volunteers may receive these through their employer, or by contacting Multnomah County Health Department's Occupational Health Office (503-988-3406), which provides these services to Coalition volunteers free of charge. Volunteers must also be immune to measles, Rubella and chickenpox.

**I have read and understand the requirements on blood born pathogens, Hepatitis B vaccination, and PPD testing. I am currently in compliance, or will comply within 10 days of beginning my volunteer service.**

_____	_____
Signature	Date

**COMMENTS / ADDITIONAL INFORMATION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All information provided in this application is true to the best of my knowledge:**

_____	_____
Signature	Date

## ATTACHMENT A

### PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Please list any past or current professional liability claim or lawsuit, which has been filed against you in the past three (3) years. **Photocopy this page as needed and submit a separate page for EACH claim/event.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's Name (print or type):

Month / Day / Year of the incident: and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month / Day/ Year the suit or claim was filed:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit of other action:

Month / Day / Year of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

**I verify the information contained in this form is correct and complete to the best of my knowledge.**

Signature:

Date:

## **ATTACHMENT B**

# **LIABILITY PROTECTION PROVIDED BY MULTNOMAH COUNTY**

This attachment summarizes

- a) Multnomah County's approach to providing malpractice liability protection for licensed professionals who volunteer in Coalition clinics, and
- b) Multnomah County's expectations of Coalition clinics and their volunteers.

### **THE OREGON TORT CLAIMS ACT**

The Oregon Tort Claims Act (OTCA) in Oregon Revised Statutes 30.260 to 30.300 provides the legal framework for liability protection for Oregon's state and local governments. The OTCA is designed to protect governments and their employees. The OTCA basically does two things:

- 1) It limits the amount of damages a claimant can receive from the state or a local government for an injury or other harm arising out of the actions of the government or its employees and agents.
- 2) It requires the County to:
  - a) provide a legal defense for employees against whom a claim of injury is made so long as the employee was acting within the course and scope of their assigned duties, and
  - b) cover the costs of any payment made as a result of such a claim (whether due to settlement, or a judgment of a court). The County pays for these costs through a combination of self-insurance and excess insurance policies. So under the OTCA, it is the government who is responsible for paying the costs arising from a successful claim – not the employee.

### **BACKGROUND**

More than 20 years ago, Multnomah County decided to extend liability protection to licensed health professionals who volunteer to provide patient care in clinics that are members of the Coalition of Community Health Clinics. The County did this in order to increase our community's capacity to provide health care for low-income and uninsured Multnomah County residents. The County judged that Coalition clinics were supporting the County's mission of providing medical care to specific populations in need. In effect, Coalition clinics were acting on behalf of the Health Department which is part of Multnomah County government.

The history of negligence claims against Coalition clinics and their volunteers has been extremely benign over the past 20 years. To the best of our knowledge, no claims have been filed, none of which have resulted in liability for either the County or individual voluntary health care professionals.

### **THE ROLE OF MULTNOMAH COUNTY**

The County designates County-credentialed licensed health professionals who volunteered in Coalition clinics as "agents" of the county. Agents enjoy the same liability protections as county employees as outlined above. In a practical sense what this means is:

- If a claim is filed against a licensed health care professional as a result of their service as a volunteer in a Coalition clinic, the Office of the County Attorney will provide a legal defense for the volunteer.
- If there are financial damages as a result of a successful claim, the County will pay these damages.

### **LIMITATIONS TO LIABILITY PROTECTIONS**

It is critical to understand that there are limits to the County's ability to defend and indemnify Coalition clinic volunteers:

- 1) The County's liability protections apply only to claims made in State of Oregon courts. The County cannot assume liability for claims filed in federal courts (although federal courts are rarely the venue for healthcare malpractice claims).
- 2) The County's liability protections only apply to volunteers' actions that are consistent with the usual practice of health care within the community. Actions outside this usual scope and course will not be defended by the County, nor will damages be covered by the County. Examples of actions that would not be covered include:
  - health care practices that are outside of the usual scope of practice of a given licensed profession,
  - unprofessional or inappropriate social or sexual interactions with patients, and
  - any activities not directly related to patient care.
- 3) The County will attempt to position itself as the responsible party in case of a valid claim. However, the County cannot guarantee that it will be successful in focusing liability on itself; a claimant might succeed in making a claim and both against the County and an individual healthcare professional.

In December 2006, the Oregon Supreme Court ruled on a case known as *Clarke vs. OHSU*. The Multnomah County Attorney has reviewed the implications of this case, and is of the opinion that the liability protections offered by the County to Coalition clinic health care professional volunteers remains intact.

### **THE COUNTY'S EXPECTATIONS OF COALITION CLINIC VOLUNTEERS**

The following represents the County's basic expectations and requirements of licensed healthcare professional volunteers who wish to

receive malpractice protection from Multnomah County.

- 1) You must be currently licensed as one of the types of health care professionals that the Health Department designates as eligible for coverage. This includes but is not limited to: MD/DO, Dentist, Nurse Practitioner, Naturopathic Physician, Chiropractor, Registered Nurse, Retired Physician, Physician Assistant, Podiatrist, Acupuncturist, Optometrist, Licensed Massage Therapist, Registered Dietitian, Licensed Clinical Social Worker, Licensed Psychologist, Certified Laboratory Technician, Licensed Physical Therapist, Occupational Therapist, Certified Medical Assistant or any licensed or certified health care professional approved by the Health Department Medical Director on a case by case basis
- 2) You must submit a Coalition of Community Health Clinics Credentialing Application, and that application must be approved by Multnomah County Health Department before you are covered. The County will not provide coverage to any licensed healthcare professional who is not credentialed by the Health Department.
- 3) You must report to the County and any Coalition clinics where you practice within three business days:
  - a. Any restriction or limitation on your professional license that has been imposed since the time you are credentialed by Multnomah County Health Department.
  - b. Any restriction or limitation on professional credentials or privileges you have received from any organization that performs health-care credentialing.
- 4) When serving in a Coalition clinic, you must practice within the usual scope of your profession as generally practiced in the community.
- 5) If you become aware of any claim or threat of a claim against you or a Coalition clinic in which you serve, you must report this within three business days to clinic supervisor or director.
- 6) If you become aware of any problems in patient care, or situations which you believe might lead to a claim, you must report the situation within seven business days the clinic supervisor or director.

As a volunteer of the Multnomah County Health Department, you are protected by the provisions of the Oregon Tort Claims Act. The County will defend, save harmless, and indemnify you from malpractice claims and liability arising from your volunteer placement as long as you limit the scope of your duties to assigned tasks and perform your work in good faith, in a manner that is not reckless or with intent to harm others **and report any claims arising from your volunteer work to the Multnomah County Health Department.** This protection is stated in the Oregon Tort Claims Act, ORS 30.260 - 300 and Administrative Guidelines HRS.05.05 and LEG.01.04.

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



**MULTNOMAH COUNTY**  
HEALTH DEPARTMENT  
Volunteer Health Care Provider Indemnification

**VOLUNTEER REFERENCE CHECK**

Dear Volunteer:

Please:

1. Fill out this first page, listing information on your reference(s);
2. Sign and date the release on the second page; and
3. Return all three of these pages, along with your completed application, copies of your license, board certificate(s) and DEA registration to the Volunteer Coordinator at the clinic that recruited you.

Acceptable references: your current clinical supervisor - or if you have none - two colleagues who are familiar with your professional practice.

Current Clinical Supervisor: \_\_\_\_\_ Title: \_\_\_\_\_

FAX number: \_\_\_\_\_

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

Business Phone Number: \_\_\_\_\_

Or

1) Colleague: \_\_\_\_\_ Title: \_\_\_\_\_

FAX number: \_\_\_\_\_

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

Business Phone Number: \_\_\_\_\_

2) Colleague: \_\_\_\_\_ Title: \_\_\_\_\_

FAX number: \_\_\_\_\_

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

Business Phone Number: \_\_\_\_\_



**MULTNOMAH COUNTY**  
HEALTH DEPARTMENT  
Volunteer Health Care Provider Indemnification

**VOLUNTEER REFERENCE FORM**

TO: \_\_\_\_\_ FAX: \_\_\_\_\_

DATE: \_\_\_\_\_

FROM: AMIT SHAH, MD, MEDICAL DIRECTOR, MULTNOMAH COUNTY HEALTH DEPT.  
KATE YEN, COORDINATOR

RE: REFERENCE REQUEST FOR \_\_\_\_\_ VOLUNTEER APPLICANT

**THE PERSON NAMED ABOVE HAS APPLIED TO BE A VOLUNTEER HEALTH CARE PROVIDER. S/HE HAS ALSO SIGNED A RELEASE OF INFORMATION (SEE BELOW) SO THAT WE MAY RECEIVE REFERENCE INFORMATION FROM YOU. PLEASE TAKE A MOMENT TO COMPLETE THIS FORM AND FAX IT TO THE INDEMNIFICATION PROGRAM AT (503) 988-3035.**

I hereby authorize Multnomah County Health Department and its representatives to consult with any and all third parties who have been associated with me and/or who may have information bearing on my qualifications and competence for approval as a volunteer health care provider with the Multnomah County Health Department. I hereby authorize and consent to the release of information concerning me to the Multnomah County Health Department and I release from liability all such persons, hospitals, or organizations complying with this request. I understand that this information is being requested as part of the credentialing process for volunteers.

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

**THE FOLLOWING INFORMATION MUST BE PROVIDED BY THE VOLUNTEER APPLICANT'S CURRENT CLINICAL SUPERVISOR, OR, IF THERE IS NONE, TWO COLLEAGUES HAVING KNOWLEDGE OF THE APPLICANT'S PROFESSIONAL PRACTICE.**

How long have you known the applicant professionally? \_\_\_\_\_

In what capacity have you known the applicant? \_\_\_\_\_

To your knowledge, has any disciplinary action ever been taken against the applicant?

Yes  No If yes, explain below:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the applicant displayed possible dependence on drugs or alcohol that would, in your opinion, affect his or her ability to perform professional and medical staff duties?

Yes  No If yes, explain below:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have any physical or mental conditions that would, in your opinion, impair his or her ability to practice medicine?

Yes  No If yes, explain below:

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please rank (place a check mark at the right) the applicant in the following areas:

Outstanding      Acceptable      \*\*Unacceptable      Not Observed

Clinical Knowledge and Judgement \_\_\_\_\_

Ethical conduct \_\_\_\_\_

Respect for Peers \_\_\_\_\_

Record keeping \_\_\_\_\_

Relationships with patients \_\_\_\_\_

Ability to work with staff & patients from various ethnic and language cultures \_\_\_\_\_

\*\* Provide comments regarding any unacceptable ratings: \_\_\_\_\_  
\_\_\_\_\_

Recommend without Reservations  Do not recommend

Recommend with the following reservations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**PLEASE RETURN THIS DOCUMENT VIA FAX TO:  
MULTNOMAH CO. HEALTH DEPT. (503) 988-3035 attn Terry**