ILLINOIS CANCERCARE, P.C.
Specializing in Cancer and Blood Disorders

VOLUNTEER APPLICATION

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **Zip Code:** _____ **Phone Number:** _____

Occupation: _____

Volunteer Experience: _____

Skills or Special Training: _____

Special Interest or Hobbies: _____

Personal Reference: (An adult who is not a relative but knows your work habit, such as Pastor/Priest, Professional, etc.)

Name _____	Name _____	Name _____
Phone _____	Phone _____	Phone _____
Address _____	Address _____	Address _____

Family Physician: _____ **Phone Number:** _____

In Case of Emergency Notify: _____ **Relationship:** _____ **Phone:** _____

What days do you prefer to work: _____

What hours: AM ☐ **PM** ☐ **Other:** _____

I give Illinois CancerCare permission to contact the person that I have listed as a reference to obtain information deemed relevant.

_____ _____

Applicant Signature **Date**

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Confidentiality and HIPAA

The obligation of confidentiality arises from the patient's right to privacy. When an individual enters the facility, Illinois CancerCare assumes an obligation to keep in confidence all that pertains to that individual and his/her affairs. This responsibility is shared by every person volunteering in any capacity in this facility.

It is important that information about patients, as well as employees and the business affairs of Illinois CancerCare be protected from discussion both in and out of the facility.

Betrayal of confidential trust in an injustice to Illinois CancerCare. Betrayal of that trust may impair public relations and may result in a volunteer being discharged.

It is important that you as a volunteer leave what your see and hear behind you when you leave our facility. Volunteers are required to sign a confidentiality statement upon assignment as a volunteer.

Illinois CancerCare Agreement

In my role as a volunteer of Illinois CancerCare, I recognize the necessity of maintaining the confidentiality of all patient information.

I understand that:

- Patient information will be discussed only with appropriate personnel as is necessary for patient care and the normal conduct of business.
- Access to clinical information is limited to employees and volunteers with a valid need to access that information in performance of their job.
- Under no circumstances may any patient information obtained during the course of volunteering be discussed outside of Illinois CancerCare
- Specific confidentiality policies may be reviewed with the Volunteer Coordinator relevant to the department in which I work
- I understand that any violation of the above will result in my dismissal as a volunteer with Illinois CancerCare

Applicant Signature **Date**

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Name of Prospective Volunteer _____

Name of Physician _____

Prospective Volunteer Medical Release Form

DO YOU HAVE	YES	NO	ANY RESTRICTIONS	YES	NO
Allergies	☐	☐		☐	☐
Arthritis	☐	☐	_____	☐	☐
Asthma	☐	☐		☐	☐
Back Problems	☐	☐	_____	☐	☐
Diabetes	☐	☐		☐	☐
Epilepsy	☐	☐	_____	☐	☐
Fainting Spells	☐	☐		☐	☐
Foot Problems	☐	☐	_____	☐	☐
Hearing Problems	☐	☐		☐	☐
Heart Problems	☐	☐	_____	☐	☐
Hepatitis	☐	☐		☐	☐
High Blood Pressure	☐	☐	_____	☐	☐
Tuberculosis	☐	☐		☐	☐
Mental Illness	☐	☐	_____	☐	☐

Do you have any limitations which would affect the type of volunteer duties you could perform?
Yes No If "yes", please explain. _____

Are you presently under doctor's care?
Yes No If "yes", please explain _____

THIS SECTION TO BE FILLED OUT BY YOUR PHYSICIAN

☐ I see no medical reason why this person may not volunteer.

☐ This person may volunteer but with the following restrictions _____

☐ This person should not volunteer.

_____ _____

Physician Signature **Date**

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