

REMOTE AREA MEDICAL®
RAM Palm Beach County MEDICAL Volunteer Registration Form

Date(s): April 10-11 2010 Location: West Palm Beach, FL Country: USA Expedition #: _____

NAME: _____ PHONE (primary): _____

ADDRESS: _____ EMAIL: _____

PROFESSION: _____

Please specify medical or vision profession (cardiologist, urologist, ophthalmologist, optometrist, optician, ophthalmic tech etc.):

Emergency Contact: _____ Relationship: _____ Phone #: _____

JOB ASSIGNMENT (CIRCLE ONE):

Medical: MD DO FNP PA **Triage:** RN LPN EMT **Pharmacy:** Pharmacist Certified Pharmacy Tech

Vision: Ophthalmologist Optician Optometrist Optical Tech Support OTHER: _____

Dental: Dentist Dental Hygienist Dental Assistant Dental Support OTHER: _____ Specialty _____

Support: Patient Registration Volunteer Registration Patient Escort Security Grounds Parking Other: _____
(Non-medical volunteers)

DATES FOR WHICH YOU ARE VOLUNTEERING CHECK all that apply:

(The clinic opens at 6am Saturday and Sunday - Volunteers should plan to arrive by 5:30 am each day)

DATES YOU ARE VOLUNTEERING (circle all that apply) SATURDAY: Apr 10 SUNDAY: Apr 11

SHIFTS YOU ARE VOLUNTEERING (circle all that apply)

Sat 04/10 6am-12pm

Sun 04/11 6am-12pm

Sat 04/10 12pm-6pm

Sun 04/11 12pm-6pm*

*(time may vary depending when event ends)

Time Log CLINIC #

City/State and Zip: West Palm Beach, Florida 33411

PLEASE EDIT TO ACCOMMODATE YOUR SHIFTS

**** I am willing to see patients for emergency follow up care. I can see _____ patients.**

Licensed Professional Compliance Statement: I hereby attest that my license/certificate is not restricted, suspended, or revoked nor is any such action pending, pursuant to disciplinary proceedings in any jurisdiction. **A COPY OF MY CURRENT STATE LICENSE OR CERTIFICATE AND DEA# (where applicable) IS ATTACHED.**

Confidentiality Statement: I understand that while I am participating as a registered volunteer at the Remote Area Medical® Clinic, it is mandatory that I maintain complete privacy and confidentiality of all patients. This pertains to all present and future digital, written, and verbal communications referring to any Remote Area Medical® Clinic patient. I also understand that unless I am obtaining information strictly for patient registration, I DO NOT ASK a patient any questions regarding medical insurance coverage, Medicaid, or Medicare. Further I agree not to photograph or record patients while at RAM. I acknowledge that I have read, understand, and agree to adhere to this policy of confidentiality for the Remote Area Medical® Clinic.

Release and Indemnification: I hereby release and indemnify, Remote Area Medical® and the United Cancer Foundation Inc., non-profit and charitable organizations, and all its respective officers, directors, agents, contractors, heirs, successors and assigns, from prosecution or presentation of any claim for bodily injury or death or for property loss or damage incurred in connection with this RAM Palm Beach County expedition or related activities.

I fully understand that I am volunteering at my own risk and that due to my occupational/other possible exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection or other blood borne pathogens. I understand if I do not have the HBV vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Printed Name

Signature

Date

Florida License Certification

RAM Palm Beach County is a program of Remote Area Medical®.
Located at: 1834 Beech St. • Knoxville, TN 37920 • 1-865-579-1530

Please return form to: United Cancer Foundation, 1200 North Federal Hwy suite 200, Boca Raton, FL 33432
Or fax to: 561-637-1914. If you have any questions, email steve@unitedcancerfoundation.org

RAM IS A TOBACCO-FREE EVENT!!! SERVICE ANIMALS ONLY