

REMOTE AREA MEDICAL®
RAM Los Angeles Volunteer Registration Form

Date(s): August 11 – August 18, 2009 **Location:** Los Angeles (Inglewood) California **Country:** USA **Expedition #:** 576

NAME: _____ **PHONE (primary):** _____

ADDRESS: _____ **EMAIL:** _____

PROFESSION: _____

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

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: _____

DATES/SHIFTS FOR WHICH YOU ARE VOLUNTEERING (Preference is given to volunteers who can work all day) Circle all that apply:

Set Up: List days and times: August 10 or 11: _____

Tuesday, August 11: All Day / 6am – 12 noon / 12 noon – 6pm **Wednesday, August 12:** All Day / 6am – 12 noon / 12 noon – 6pm

Thursday, August 13: All Day / 6am – 12 noon / 12 noon – 6pm **Friday, August 14:** All Day / 6am – 12 noon / 12 noon – 6pm

Saturday, August 15: All Day / 6am – 12 noon / 12 noon – 6pm **Sunday, August 16:** All Day / 6am – 12 noon / 12 noon – 6pm

Monday, August 17: All Day / 6am – 12 noon / 12 noon – 6pm **Tuesday, August 18:** All Day / 6am – 12 noon / 12 noon – 6pm

Take Down: August 19: _____

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

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 release and indemnify Remote Area Medical, a non-profit organization, 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 Remote Area Medical 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 bloodborne pathogens. I understand if I do not have the HBV vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I want to be vaccinated with Hepatitis B vaccine, I can acquire the vaccination at my own expense.

Printed Name

Signature

Date

State and Country of Licensure/Certification

Remote Area Medical is a 501(c)(3) medical relief charity located at 1834 Beech Street, Knoxville, TN 37920, 423-579-1530 **Medical & Vision Licensed Health Professional & Support Volunteers. Please return form and copy of current license (if applicable) to:** Jean Jolly, Remote Area Medical, 1834 Beech Street, Knoxville, TN 37920 or fax to 865.609.1876. Questions may be directed to Jean Jolly at 865.579.1530 or jeanjolly@ramusa.org

