St. Raphael's Dental Clinic

Dental Professional Volunteer Application

We are excited that you have expressed interest in joining the Volunteer Team at St. Mary's Dining Room. We rely on volunteers like YOU to help provide compassionate, free medical and dental care to the individuals and families experiencing homelessness and poverty in San Joaquin County.

We trust your volunteer experience will be a positive one!

What prompted you to consider volunteering?

NOTICE If you need to complete community service hours for school/academic requirements, court, work, or any other reason, please contact Georgie Nguyen at (209) 467-0703 to learn more about our **Community Service (CS) Program.** Do not submit a volunteer application.

- ☐ **YES, I need to complete mandated community service hours.** Please contact Georgie, you must enroll into a different program called Community Service (CS) Program.

- ☐ **NO, I do not need my hours tracked and verified.** I understand that volunteer hours are not tracked and verified and cannot be signed off by St. Mary's Dining Room.

OTHER

- ☐ Recruited by a peer: ________________
- ☐ Support community need
- ☐ Professional networking
- ☐ Rewarding experience

VOLUNTEER APPLICATION

PERSONAL INFORMATION

FIRST NAME ______________ **LAST NAME** ______________

STREET ADDRESS ______________

CITY ______________ **STATE** ______________ **ZIP CODE** ______________

HOME PHONE ______________ **MOBILE PHONE** ______________

EMAIL ADDRESS ______________

D.O.B. ______________ **BILINGUAL** ☐ Yes ☐ No **LANGUAGE:** ______________

EMPLOYMENT STATUS

☐ This is my current employer
☐ This is my most recent employer

EMPLOYER ______________ **CONTACT #** ______________

ADDRESS ______________

JOB TITLE ______________ **MAY WE CONTACT?** ☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION

CONTACT
FIRST NAME ______________ **LAST NAME** ______________

PHONE NUMBER ______________ **RELATIONSHIP** ______________

REFERENCES: Please list two professional references below.

FULL NAME ______________ **RELATIONSHIP** ______________

COMPANY ______________ **CONTACT #** ______________

ADDRESS ______________

FULL NAME ______________ **RELATIONSHIP** ______________

COMPANY ______________ **CONTACT #** ______________

ADDRESS ______________

REQUIRED VOLUNTEER DOCUMENTS

Applications received with any of the missing required documents are considered incomplete and will not be processed. Please submit the required documents along with the completed application to the Administration Office: Monday - Friday, 8am - 4pm, (209) 467-0703, fax: (209) 467-7795 or email: volunteer@stmarysdiningroom.org,

VACCINATIONS - St. Mary's Dining Room strongly recommends volunteers to receive the seasonal influenza (flu vaccine) and Hepatitis B vaccine prior to volunteering on our campus.

REQUIRED DOCUMENTS	**DATE SUBMITTED** (For Staff Use)
☐ **Copy of Identification** ☐ Driver's License, Government Issued ID	______________________
☐ **Copy of License/Certifications**	______________________
☐ **Copy of Malpractice Insurance** (For all practicing providers) General Liability Coverage	______________________

For volunteer hygienists and other dental volunteers only:

I acknowledge that St. Mary's Dining Room does not provide malpractice insurance.
It is my responsibility to provide my own malpractice insurance if I choose to do so.

Signature: ____________________________________ **Date:** _________________

AVAILABILITY

☐ Daily ☐ Weekly ☐ Monthly

Please check months and days. Indicate available session (AM/PM) and exact available times.

☐ January	☐ February	☐ March	☐ April
☐ May	☐ June	☐ July	☐ August
☐ September	☐ October	☐ November	☐ December

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
AM						
PM						

COMMENTS:

____

____

____

DOCTOR/RDH PROFILE

NAME: ______________________ **DDS** **DMD** **RDH**

Will bring own RDA? ☐ **Yes** ☐ **No** **Name of RDA:** ______________

RDA will also need to register as a volunteer and provide required documents

OFFICE ADDRESS: ______________________

CITY ________ **STATE** ________ **ZIP CODE** ________

OFFICE PHONE ________ **MOBILE PHONE (FOR EMERGENCY ONLY)** ________

Do you prefer to work with another doctor? ☐ **Yes** ☐ **No**

Will you supervise RDHs? ☐ **Yes** ☐ **No**

X-ray preferences (digital) ☐ **BWx4** ☐ **PA** ☐ **3D**

Glove size and preference ☐ **XS** ☐ **S** ☐ **M** ☐ **L** ☐ **XL**
☐ **Nitrile** ☐ **Latex** ☐ **Powderfree**

Mask ☐ **Earloop** ☐ **Facemask** ☐ **Cone**

Circle all that apply, and you wish to do: (Note we will try to accommodate when possible)

Anesthetic ☐ **Topical** ☐ **Lidocaine** ☐ **Septocaine** ☐ **Marcaine** ☐ **Carbocaine** ☐ **Plain (no epi)**

PEDO ☐ **Yes** ☐ **No**

PERIO ☐ **Yes** ☐ **No** ☐ **Prophy** ☐ **Root Planning** ☐ **Ultrasonic Scaler** ☐ **Sonic Scaler**

ORAL SURGERY ☐ **Yes** ☐ **No**

Types
☐ **Simple Extractions** ☐ **Multiple Extractions**
☐ **Simple Impactions** ☐ **Partial Soft Tissue**
☐ **Partial bony** ☐ **Full bony** ☐ **3rd Molars**
☐ **Alveoloplasy** ☐ **Full Mouth (Prep for FUD FLD**

☐ **Forceps** ☐ **Max 150** ☐ **Mn 151** ☐ **Anterior** ☐ **Curette** ☐ **Elevator S M L**
☐ **Pick** ☐ **Pots** ☐ **Suture** **Type:** ________

Amalgam ☐ **Yes** ☐ **No** **Amalgam Instrument** ☐ **Hollenbeck** ☐ **DiscoCleoid** ☐ **Acorn**

Composite ☐ **Yes** ☐ **No** **Class** ☐ **1** ☐ **2** ☐ **3** ☐ **4**

Composite ________ **Flowable** ________ **Etch** ________

Bonding system ☐ **SE Bond** ☐ **Opti Bond** ☐ **Solo** ________

Matrix system ☐ **Tofflemier** ☐ **Garison** ☐ **Other** ________

ENDO ☐ **Yes** ☐ **No** ☐ **1 Canal** ☐ **2 Canals** ☐ **3 Canals** ☐ **4 Canals**
☐ **Pulotomy Formo** ☐ **Other**
☐ **Hand pieces preference** ________ ☐ **Electric** ☐ **Fiber Optic**
Stainless Steel Crowns ☐ **Yes** ☐ **No**
Preferred Cement ________
Crown Cement Preference ________

REMOVABLE DENTURES ☐ **No Dentures** ☐ **Adjustments** ☐ **Stay Plates** ☐ **Bite**
☐ **Try In** ☐ **Delivery** ☐ **Immediates**

PARTIAL DENTURES ☐ **No Partials** ☐ **Bite** ☐ **Try In** ☐ **Delivery**
☐ **Adjustment** ☐ **PO** ☐ **Immediates**

INFORMATION ON HEPATITIS B AND (HBV VACCINE)

St. Mary's Dining Room strongly recommends volunteers in the healthcare industry to consider the Hepatitis B vaccine (HBV vaccine) prior to volunteering on our campus.

HEPATITIS B: According to the Centers for Disease Control and Prevention (CDC), Hepatitis B is a liver infection caused by the Hepatitis B virus (HBV). The Hepatitis B virus is transmitted when blood, semen, or another body fluid from a person infected with the virus enters the body of someone who is not infected. For some people, Hepatitis B is an acute, or short-term, illness but for others, it can become a long-term, chronic infection. Risk for chronic infection is related to age at infection: approximately 90% of infected infants become chronically infected, compared with 2%–6% of adults. Chronic Hepatitis B can lead to serious health issues, like cirrhosis or liver cancer. The best way to prevent Hepatitis B is by getting vaccinated.

For more information, please visit: https://www.cdc.gov/Hepatitis/hbv/index.htm

THE HBV VACCINE: A high percentage of healthy people who receive three doses of this vaccine achieve high levels of surface antibody (**HBsAb)** and protection against Hepatitis B. Full immunization requires three doses of vaccine given over a six-month period. There is no evidence that the vaccine has ever caused Hepatitis B or AIDS (Acquired Immune Deficiency Syndrome). Individuals infected with HBV prior to receiving the vaccine may go on to develop clinical Hepatitis in spite of immunization. The duration of immunity is unknown at this time, but long-term protection is probable.

- I have read the above statement about Hepatitis B and the (HBV vaccine).
- I understand St. Mary's Dining Room strongly recommends all volunteers to be vaccinated due to the volunteer exposure to blood and/or other infectious materials. Volunteers may be at risk of acquiring Hepatitis B virus. I understand I must have all three (3) doses of vaccines to develop immunity. There is no guarantee that I will become immune.
- Please speak to your primary health care provider for more information on (HBV vaccine).

☐ **I have completed the HBV vaccination series.** *Completion Date:*___________________

☐ **I do not wish to take the HBV vaccination series at this time.** *Initials:* ____________
Must complete the Informed Refusal for Hepatitis B Vaccination page.

☐ **I have been diagnosed with Hepatitis B in the past.** *Date:* ____________

_______________________________ _________________
Print Name **Date**

____
Signature

St. Mary's Dining Room

Informed Refusal for Hepatitis B Vaccination – *Confidential*

I, ____________________________________ am volunteering as ________________________________.
(First & Last Name) (Volunteer Position)

St. Mary's Dining Room has provided me information regarding the Hepatitis B (HBV) and (HPV vaccine) and strongly recommends volunteers to be vaccinated. I understand that due to my volunteer exposure to blood and/or other potentially infectious materials, I may be at risk of acquiring the (HBV) infection. I have the option of being vaccinated for my own safety and health prior to volunteering at St. Mary's Dining Room.

However, I decline (HBV vaccine) at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring (HBV), a serious disease. St. Mary's Dining Room cannot be held responsible for any contracted diseases and/or health related issues throughout my volunteer experience.

____
Signature Date

____

____

____
Address

Maintain this record for duration of volunteerism plus 30 years.

St. Raphael's Dental Clinic

Volunteer Agreement

St. Mary's Dining Room strives to make the volunteer experience a positive one for all who generously donate their time to our agency's mission. In our efforts to maintain this level of care, it is important to follow general guidelines for the well-being of volunteers, staff, community members and clients.

As a volunteer at St. Mary's Dining Room St. Raphael's Dental Clinic I agree to:

- Volunteer license(s), certification(s) and malpractice insurance must always be renewed and up to date while participating on our campus.
- Report on time for the scheduled shift and sign-in/out in the volunteer log.
- Dress appropriately for each volunteer shift.
- Follow all clinic policies, safety procedures, instructions and assigned tasks.
- Front office volunteer cannot participate in the back office where the dental professionals and staff provide dental care/services.
- Notify the clinic manager as soon as possible of any cancellations or change to my volunteer schedule.
- Respect all St. Mary's Dining Room staff and fellow volunteers.
- Provide health care services with courtesy and respect to all patients and their family members.
- Volunteers have the right to work in an environment free from harassment. Should any issues arise please report to the appropriate supervisor immediately.

If at any time volunteer service is found to be unsatisfactory or if the provided services are no longer needed, the clinic reserves the right to dismiss volunteers.

____
Print Name
(First & Last Name)

____ __________________________
Signature **Date**

St. Raphael's Dental Clinic

Confidentiality Agreement

I, ____________________________________,
(First & Last Name)

understand that all information I am exposed to regarding patients, program participants, volunteers, family members of patients/volunteers, customers, and/or employees of the clinic, work place wellness, and their partners/collaborators may be governed or protected by Federal, State and/or local regulations and where privileged, is said to be held in the strictest confidence:

- No privileged information will be discussed with family, friends, or any other unauthorized person
- I may release only information that is duly authorized for release and for which I have training and authorization to release
- Unauthorized disclosure is cause for termination of volunteer services as well as possible civil and/or criminal sanctions

Furthermore, I hereby agree to:

- Release only that information that is duly authorized for release
- Resist any effort or request for information that is protected by relevant federal, state, and/or local regulations
- Not divulge, publish, or otherwise make know to unauthorized persons or the public any confidential information obtain in the course of my participation with clinic activities; institute or comply with appropriate procedures for safeguarding such information and will hold discussions only in place which assure privacy, and only on a need to know basis

____
Print Name
(First & Last Name)

____ ____________________________
Signature **Date**

VOLUNTEER GUIDELINES

Please keep this page for your personal reference.

Schedule – Once approved, our dental clinic staff will contact volunteers to set up their schedule.

Volunteer Shifts – Volunteers are asked to arrive on time for their shifts. This is extremely important as it helps to keep the clinic running smoothly. Please call ahead to let the clinic manager know if you will be delayed. If you have volunteered for a shift and become ill, please let the clinic supervisor know as soon as possible so that a replacement volunteer can be found.

Dress Code – The dress code for the dental clinic is either lab coats or scrubs. Please refrain from the use of scented lotions, perfumes and acrylic – false nails. We do ask that volunteers wear close toed, non-slip shoes.

Equipment/Dispensary – No volunteers can access equipment, the dispensary and/or medications unless authorized by dental /medical SMDR staff only.

Parking – Parking is available in front of the dental clinic and at the gated lot across from the main entrance.

Phone Use – Please silence cell phones during clinic hours. Cellphone usage may only be used during break.

Professional Environment – Please help us maintain a professional environment in the clinic by presenting yourself in a professional manner when volunteering. In the clinic, physicians and providers appreciate a quiet space in which to consider their patient case while they make chart notes and referrals.

Personal Belongings – Please do not bring valuables or medications to the clinic during your shift.
We do not have a place for storage. The clinic assumes no responsibility for lost or stolen valuables.

Issues/Concerns – Please report all issues and concerns to dental staff immediately.