Name:_____Date of Birth:_____

Mailing Address:_____

Phone:_____

Email:_____

Emergency Contact Name:_____Emergency Contact Phone:_____

Have you every been arrested convicted of a felony? If yes, please explain:

_____

_____

_____

Mission Statement:

The mission of Trinity Health Ministries Inc. is to follow Christ's command to provide physical, emotional, and spiritual care to members of our community who are unable to access these services through tradition channels.

Do you have any questions about our mission statement?

_____

_____

How did you learn about Trinity Dental Clinic?

_____

_____

Do you have any volunteer experience? If so, please list previous volunteer experience:

_____

_____

State Briefly Why you wish to volunteer at Trinity Dental Clinic:

_____

_____

In what area or role would you like to volunteer in at Trinity Dental Clinic? (Circle all that apply)

Dentist	Dental Hygienist	Dental Assistant
Lab Sterilization	Fundraising	Office Staff (Clerical Area)

Volunteer Pledge

I pledge: (Please Initial)

____My conscientious effort to fulfill my duties.

____To conduct myself professionally, with tact, consideration and understanding

____To hold all information regarding patients (which I see and hear) confidential

____To understand that I will seek only information "I need to know" to perform my work

____To be loyal to the mission of Trinity Health Ministries, Inc.(Trinity Dental Clinic)

____To attend any necessary training and orientation sessions.

I certify that the information given by me in this application is true in all respects and agree that if accepted this information is found to be false in any way, I may be subject to dismissal without notice.

Signature:_____Date:_____

Confidentiality Agreement

I understand that the information that I receive about board members, volunteers and staff and clients is confidential. This includes the identity of individuals and families. This information is to be discussed only with the board of Directors and /or their designees and or health professionals assigned to the designated case.

If at any time I suspect that a child or elderly client has been the victim of abuse or neglect, I will contact the Department of Health and Human services and a designated Board Member.

If I am found to have breached this confidentiality agreement, I realize that my position will be terminated.

Print:_____Signature:_____Date:_____