

APPLICATION FOR PROFESSIONAL VOLUNTEER PRACTICE

Dear Colleague:

Thank you for your interest in Casa de Salud. We depend on volunteer health professionals for our service delivery. The application process includes standard steps for all Casa volunteers and additional steps for professional credentialing that takes place every three years. Please use the **Application Checklist on page 2** to ensure your packet is complete. Please also review and sign the below information about Casa to make sure that this opportunity is a good fit for you.

What is Casa de Salud?

Casa is a welcoming place that facilitates ongoing patient-centered health care. As such, Casa provides –

- Medical care for episodic and chronic conditions;
- Limited specialty care including psychiatry, gynecology, dermatology, and others
- Basic screening and prevention services
- Dietetic/nutrition counseling, physical therapy, diabetes education, foot care, audiometry and limited mental health counseling

Casa also provides *medical case management* for health needs unable to be met at Casa, including:

- Referrals to other health care facilities
- Navigation (accompaniment) to appointments at other health care facilities
- Support with financial assistance for health care
- Home visits for support/education regarding chronic health management
- Patient advocacy, as needed

Casa de Salud’s Mission

To facilitate and deliver basic high quality clinical and mental health services for uninsured and underinsured patients, focusing on new immigrants and refugees who encounter barriers to accessing other sources of care.

Casa de Salud believes that...

- our patients are our first priority.
- we should serve our patients using a volunteer professional staff who deliver care with integrity, compassion, respect, and dignity for all.
- health and wellness include physical, mental, social, emotional, spiritual and environmental health.
- we should not duplicate existing local services and should assist patients in finding care within the St. Louis healthcare system.
- we should be good citizens in the healthcare community, maintaining strong ties with other providers to promote health and wellness for all of our people.

I understand Casa’s Mission, Beliefs, and Practices, and agree to provide care in accordance with them:

Signature

Name

Date



CASA de SALUD

HEALTHCARE PROFESSIONAL APPLICATION CHECKLIST

- Application for Professional Volunteer Practice (pages 1, 3-6)
- Confidentiality Form (page 7)
- Photo Release Form (page 8)
- CV or resume
- Copies of professional licenses and other certifications (submit at initial application and at each relevant renewal)
 - Current Missouri full, permanent professional License
 - Board Certification(s) (if applicable)
 - Current DEA (if applicable)
 - Current BNDD (if applicable)
- Complete background check through Saint Louis University (Instructions page 9)
- Documentation of TB screening within past 12 months (may obtain at Casa)
- Documentation of Hepatitis B immunity
- Documentation of HIPAA training within the past 12 months (may obtain at Casa)
- Documentation of Blood Borne Pathogen training within the past 12 months (may obtain at Casa)
- Review & sign quick Tips for Working with Interpreters (page 10)
- Spanish Proficiency Assessment if planning not to use an interpreter (schedule with Casa staff)

CASA DE SALUD

3200 Chouteau Ave., St. Louis, MO 63103 • Phone 314-977-1250 • Fax 314-977-1255

PERSONAL INFORMATION :

DATE: _____

NAME:

LAST	CREDENTIALIALS,	FIRST	MIDDLE
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DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

PRESENT ADDRESS: _____

PHONE NUMBERS: _____

OFFICE	CELL	HOME
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EMAIL ADDRESSES: _____

PERSONAL	WORK
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How did you hear about volunteering at Casa: _____

AREA OF PROFESSIONAL EXPERTISE

- Physician – Specialty: _____ Taxonomy Code: _____
- Nurse Practitioner – Specialty: _____
- Licensed Clinical Social Worker Registered Nurse
- Physician’s Assistant Registered Dietician
- Other: _____

AVAILABLE HOURS

FREQ: [] DAILY [] WEEKLY [] MONTHLY [] OTHER DAY(S):	MORNING	AFTERNOON	EVENING
	Specify exact times available		
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			

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UNIVERSITY EDUCATION AND RESIDENCY/FELLOWSHIP PROGRAMS

REFER TO CV OR RESUME (no need to complete if checked)

Years	University	Degree	City	State

LICENSE AND BOARD CERTIFICATIONS

Please attach copies of current license, DEA, BNDD, and Board Certification

LICENSE #	STATE (MO required)	EXPIRATION DATE
BOARD CERTIFICATION(S)		EXPIRATION DATE

Are you registered with St. Louis County's Prescription Drug Monitoring Program?

Yes **No**

CURRENT AND PAST PRACTICE

REFER TO CV OR RESUME (no need to complete if checked)

Years (From-To)	Name of Practice	Address	City/State/Zip	Phone

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NAMES OF THREE PROFESSIONAL REFERENCES

Name	Phone Number	Email

LANGUAGES: BILINGUAL/MULTILINGUAL

SPANISH: Yes___ No ___	Please Schedule Proficiency Assessment if not planning to use an interpreter.
OTHER: (Specify):	PROFICIENCY (Circle One): Rudimentary Basic Advanced Bilingual

IN CASE OF EMERGENCY NOTIFY

NAME	ADDRESS	PHONE

PLEASE RESPOND TO THE QUESTIONS BELOW. IF THE ANSWER TO ANY QUESTION IS YES, PROVIDE A DETAILED EXPLANATION ON A SEPARATE PAGE(S):

1. Have you ever been the subject of a disciplinary or investigative proceeding or been reprimanded by a governmental or administrative agency, hospital or professional association?
YES NO
2. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?
YES NO
3. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
YES NO
4. Have you had any state professional license, board certification, or license to prescribe or dispense narcotics challenged, refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?
YES NO

Printed Name

Signature

Date

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**PHYSICIAN & HEALTHCARE PROVIDER
AUTHORIZATION, ATTESTATION AND RELEASE**

In connection with applying to serve as a volunteer physician or provider at Casa de Salud, I agree to the following.

AUTHORIZATION. I authorize and grant consent to Casa de Salud and its agents to obtain a consumer report or an investigative consumer report. The report may include inquiries to federal and state law enforcement agencies (e.g., criminal background checks), each licensing board from which I have been issued a license, and the National Practitioner Data Bank as part of an evaluation of my credentials for practice as a volunteer physician of Casa de Salud. I further authorize Casa de Salud and its agents to consult with and, if necessary, obtain and review documents from current and previous employers, malpractice carriers (including, but not limited to, claims history), managed care companies, hospitals or other health care facilities, educational institutions, and persons or entities who have been associated with me and/or who may have information bearing on my competence, character, general reputation, personal characteristics, mode of living, qualifications or professional conduct or that is otherwise relevant to my practice as a volunteer physician or provider of Casa de Salud. Upon the request by Casa de Salud or its agents, I agree to complete and sign any forms or documents as may be required by third parties in order to carry out the purposes of the authorizations granted herein. The authorization granted in this paragraph expires one (1) year from the date set forth by my signature below.

ATTESTATION. I certify that all information provided on this form, on the Application for Professional Volunteer Practice, in any information otherwise provided by me to Casa de Salud, and all other representations previously made by me to Casa de Salud are true, correct and complete and are not misleading. The terms of this paragraph survive termination of the authorization above.

RELEASE. I release Casa de Salud from any liability in connection with conducting a review of my background as contemplated above and/or for relying on any information provided by me or by individuals and organizations pursuant to the Authorization above, including information concerning my credentials, professional competence, ethics, character and other qualifications for practice as a volunteer physician or provider of Casa de Salud. The terms of this paragraph survive termination of the authorization above.

*Either an original or a photocopy of this form to be used for the purposes set forth herein.

Printed Name

Signature

Date

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VOLUNTEER CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

(signed copy to be kept in volunteer file.)

I, _____, do affirm that I will not divulge *CASA DE SALUD* data to any unauthorized person for any reason. Neither will I directly nor indirectly use, or allow the use of, *CASA DE SALUD* data for any purpose other than that directly associated with my volunteer assigned duties. I understand that ALL PATIENT INFORMATION, including financial data, is strictly confidential.

Furthermore, I will not – either by direct action or by counsel – discuss, recommend or suggest to any unauthorized person the nature or content of any *CASA DE SALUD* information.

I agree that any violation of this agreement is cause for termination.

I understand that signing this document does not preclude me from reporting instances of breach of confidentiality.

Signed

Date

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AUTHORIZATION FOR RELEASE AND USE OF VOLUNTEER IMAGE

(Signed copy to be kept in volunteer file.)

I _____, hereby authorize *Casa de Salud*, or its designee, to:

1. to use my image, including but not limited to, my name, photograph, picture, portrait, digital image, video, likeness, statements and voice (hereinafter collectively known as my "Image"), for the purpose of *Casa de Salud* publicity and educational purposes;
2. to use, reproduce, publish, exhibit, distribute, and transmit my image individually or in conjunction with other images or printed matter, including but not limited to video tapes, sound recordings, still photographs, digital reproductions, or any other form of media;
3. to record, reproduce, amplify and simulate my image and all sound effects produced;
4. to assign the above-mentioned rights to third parties.

I hereby waive the right to inspect or approve my image or any finished materials that incorporate my image. I understand and agree that I will receive no compensation, now or in the future, in connection with the use of my image.

I hereby release and forever discharge *Casa de Salud*, its Trustees, officers, agents and employees from any and all claims, demands, rights and causes of action of whatever kind that may arise from the use of my image, including but not limited to, all claims for defamation and invasion of privacy.

This authorization shall exist in perpetuity unless I specifically revoke my authorization in writing as explained in the *Casa de Salud* notice of privacy statement. I understand that my volunteer work or practicum will not be affected if I do not sign this form. I understand that federal privacy regulations may no longer protect the use of my image once *Casa de Salud* utilizes my image.

Name (please print): _____ Date: _____

Signature: _____ Phone Number: _____

Casa de Salud Representative Name: _____

Casa de Salud Representative Signature: _____

CRIMINAL BACKGROUND CHECK THROUGH SAINT LOUIS UNIVERSITY (SLU)

Thank you for going through these steps on behalf of Casa de Salud. The instructions below come from SLU's HR Department, but I wanted to highlight several things:

- We ask you pay up front by check or money order, and we will reimburse you. (\$82.20 if born in the U.S.; \$106.20 if born outside the U.S.) If this presents a problem, please let us know.
- You may receive a confirmation email from SLU HR that says "the appropriate hiring department will be billed for the cost of the criminal background check." This does not apply to Casa – sorry!
- Please bring your actual social security card and drivers' license or state ID.

To obtain the criminal background check, please visit the background check webpage of the Office of Clinical Education Compliance (<http://www.slu.edu/registrar/services/background-checks.php>), follow the directions on that homepage, and complete the form following the directions below. This website is secure, and the information provided on this form is confidential. Before you begin please have your driver's license or state ID and social security number available. Please complete the following:

- 1) Select the appropriate choice from the buttons below. If you live within 40 miles of the Saint Louis University campus, select HUMAN RESOURCES LOCAL. If you live more than 40 miles from the Saint Louis University campus, select HUMAN RESOURCES EXTENDED.
- 2) If you selected Human Resources Local, a criminal background check calendar will open with available dates and times for the Office of Clinical Education Compliance in DuBourg Hall Room 20, 221 North Grand Boulevard (<http://www.slu.edu/campusmap/dubourg.html>) to collect your fingerprints. Please select a date and time for your appointment and complete the following HR Criminal Background Check Request.
- 3) If you selected Human Resources Extended, please complete the HR Extended Criminal Background Check form.
- 4) On the drop menu "Human Resources" select – Casa de Salud
- 5) Complete the remainder of the form.
- 6) Complete the next screen "Authorization & Consent for Release" by entering your full name below each section and then click "submit".

Upon successful completion of the form, you will receive an email confirmation with appointment information and/or further instructions. If you have questions or need assistance with making an appointment, please call the Office of Clinical Compliance at 314-977-6636.

QUICK TIPS FOR WORKING WITH INTERPRETERS

What is an interpreter? - A person who renders a message spoken or signed in one language into a second language.

What is interpreting? - The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language, taking the cultural and social context into account. [2005 National Council on Interpreting in Health Care]

Who are Casa Interpreters? - Casa Interpreters are volunteers. They are students and working professionals who passed our Spanish Proficiency Assessment and attended Interpreting Training Practice Labs.

What happens before the patient encounter? (Pre-session for provider with Interpreter)

- The provider and interpreter will meet in the provider lounge. The interpreter name can also be found on the provider's schedule.
- It is helpful to briefly review the patient case with the interpreter, which allows them to prepare any necessary challenging vocabulary or medical terminology.

What happens during the patient encounter?

- Provider introduces him/herself and the interpreter to the patient
- Interpreter interprets the Provider's introduction and gives the following introduction
"My name is _____. I will be your interpreter today. Please speak directly to the provider. I will interpret everything that you say and everything is confidential. I will speak in the first person. If I make this gesture (raised hand with stop symbol) please stop or slow down allowing me to render all messages clearly. Thank you. "
- Provider talks directly to the patient, maintaining primary eye contact with the patient.
- Positioning is important. Providers should sit in an arrangement where they are facing the patient. The interpreter should be positioned neutrally and will shift positions in order to prevent any triangle communication.

The Do's of Working with Interpreters

- Speak clearly and slowly. Pause between sentences to allow the interpreter to render all messages clearly
- Speak directly to the patient
- Be prepared to repeat questions or instructions
- Be prepared that an interpreter may need to look up a word or ask for clarification
- If there is a medical student also in the room, be sure to tell the patient if/when you are teaching the student. Patients wonder what is not being interpreted and often understand more English than they speak.

The Don't of Working with Interpreters

- Make comments to the interpreter that are not meant to be interpreted to the patient.
- Ask patients if they speak English. (We offer interpreters by default.)
- Have side conversations with the interpreter or others in the exam room.
- Interpreters cannot be with a patient without a provider under any circumstance, including leaving them in the room briefly or sending them for clarification or to pass a prescription.

I, _____, agree to work with an interpreter in accordance with these guidelines and any subsequent training by Casa staff.

Signature: _____ Date: _____