

BUREAU OF COMMUNITY RISK POLICY

The Baltimore City Health Department will accept volunteers on the first come first serve basis provided the volunteer can provide documentation of the following:

- a. Current work or course study in public health or related field
- b. Willingness to work with the target population
- c. _____

Please fill in if your volunteers need extra supporting documents ex. Immunizations

DEFINITION:

Volunteer- Individual who undertakes and performs a service willingly and without pay for the Baltimore City Health Department.

PROCESS:

All Volunteers must submit a Baltimore City Health Department Volunteer Application and current Résumé to the Program Manager. Those volunteers with licensure must submit a copy of the current licensure to perform any duties that will require that information.

A personal interview will be set up between the volunteer and the Program Manger to discuss volunteer service. At this time both parties will decide if they wish to enter into a relationship whereby allowing the volunteer to act as volunteer program staff for our departments. Sites and times for volunteering are decided and assigned as available. The Health Department always tries to accommodate its volunteers, as we understand you are assisting us and many volunteers have work and school schedules.

Volunteer staff are trained by program staff and are allowed to perform duties alone, when they are ready, the staff and volunteers determine readiness together. It is the goal of all BCHD staff to never allow volunteers to be uncomfortable or to be unsure with any policy or duty to do so without resolving the question or concern timely and satisfactorily.

All volunteers must submit proof of immunization, if required by the department, prior to volunteering.

Volunteers will communicate with program management when they will be unable to make their scheduled time via email or phone call to their supervisor. This should be communicated at least 24 hours in advance if possible.

Volunteers are an important part of our programs. Without you we could not provide all the many services currently offered. We thank you for your interest and service and look forward to along lasting relationship.

VOLUNTEER APPLICATION

PERSONAL INFORMATION: (please type of print)

Name (Last, First, Middle): _____ Date of Birth: _____

Present Address _____

City _____

State _____ Zip Code _____

Personal Phone Number (_____) _____

Work Phone Number (_____) _____

Permanent Address (if different from above) _____

City _____

State _____ Zip Code _____

Permanent Home Phone Number (_____) _____

Area of interest: _____

Date you can start: ____/____/____

Hours Available:

Mon. ____ Tues. ____ Wed. ____ Thur. ____ Fri. ____ Sat. ____ Sun. ____

EDUCATION: (If you need more space please include another sheet)

Name	Address	Years Attended	Highest Level Completed	Subject studied
High School				
College				
Trade, Business, or correspondence school				

VOLUNTEER EXPERIENCE:

Have you ever volunteered before for Baltimore City Health Department?

____ Yes ____ No

If yes please fill out the following information.

Dates	Name of Location	Position

Other skills or training: (fluency in language, word processing skills ect.) _____

MOST RECENT EMPLOYER:

Date	Name and Address of Employer	Position	Phone number

May we contact them _____ Yes _____ No

REFERENCES: (please supply professional references)

Name	Address	Phone Number
1.		
2.		

EMERGENCY CONTACT PERSON IN CASE OF EMERGENCY:

Name	
Relationship	
Day Phone Number	

Have you ever been convicted or plead guilty in court (even if you did not have a trail) for anything other than a misdemeanor or minor traffic violation? _____ Yes _____ No

If yes, please explain: _____

As a volunteer of the Baltimore City Health Department, you will be considered an “employee” of Baltimore City for purpose of the Local Government Tort Claims Act. Therefore, you will not be liable for any tortuous acts and omissions that you commit:

1. within the scope of your duties
2. without actual malice.

This immunity is contingent o you cooperation in the defense of any action. Your signature below indicates that you acknowledge the extent and limitations of this coverage.

Applicant’s Signature

Date

AUTHORIZATION:

Your signature indicates that the facts contained in this application are true and complete to the best of your knowledge. False statements on this application shall be grounds for dismissal. You authorize approval to check references. The organization is not obligated to provide a placement, nor re you obligated to accept the position offered.

Applicant’s Signature

Date

SCOPE OF SERVICES
FOR
HEALTH DEPARTMENT VOLUNTEERS

Volunteer Name: _____

The following duties may be performed by the above named volunteer while serving as a volunteer to one of the Health Departments programs. All volunteers who perform the duties initialed below will be trained by a Health Department staff member prior to performing duties with the exception of certain duties that require documented licensure:

- **Volunteers will be permitted to exchange syringes for clients on a 1:1 basis.**
- **Volunteer may provide Hepatitis C Prevention education to clients.**
- **Volunteers may make harm reduction kits.**
- **Volunteers may assist staff in the inventory and stocking of the Needle Exchange van.**
- **Volunteers are permitted to help tidy up vehicles by wiping down tables or sweeping at shift end.**

Location: _____

Address: _____

Hours:

Mon. _____ Tues. _____ Wed. _____ Thur. _____ Fri. _____ Sat. _____ Sun. _____

Volunteers will be responsible for appropriate conduct at all times while working on city property. Volunteer staff shall be professional and courteous to clients. Volunteers report directly to:

Name: Derrick Hunt Title: Program Manager

Name: _____ Title: _____

Volunteer Signature: _____ Date ____/____/____

Manager Signature: Derrick Hunt Date ____/____/____

BALTIMORE CITY HEALTH DEPARTMENT
VOLUNTEER WORKER AGREEMENT OF CONFIDENTIALITY

As a Volunteer Worker for Baltimore City Health Department, I may have access to “Strictly Confidential” material.

Client information is strictly confidential and must be safeguarded, Client information may not be disclosed or shared with anyone other than those designated by the Baltimore City Health Department. Client information may only be disclosed or shared for purpose directly connected with my assignments for the Baltimore City Health Department. “Disclose” Means communication of client information, including an acknowledgement that information exists.

I agree to comply with and be bound by all applicable provisions of state and federal law concerning confidential information (including Maryland Annotated Care Article 88A, Section 6; Code of Maryland Regulations 07.01.07; Maryland Annotated Code, Health General Article, Title 4 Subtitle 3; Maryland Public Information Act, Maryland Annotated Code, State Government Article, Title 10, Subtitle 6; and Federal “Confidentiality of Alcohol and Drug Abuse patient Records’ Regulations, Part 2). I understand that sharing or disclosing such information unlawfully could result in discharge from the Baltimore City Health Department, fines up to \$5,000, civil liability for actual damages, and/ or imprisonment for up to 90 days.

If a Health Department client is known to me as a relative or friend, I realize that this person needs to know that confidential information from medical records will not become known to me without his/her consent. I will avoid handling the medical records of relatives and friends whenever possible, and I will not read these records under any circumstances.

I have read and understand the preceding information and agree to abide by these confidentiality provisions.

VOLUNTEER WORKER

Print Name: _____

Signature: _____

Date: _____

WITNESS

Print Name: _____ Chris Serio-Chapman _____

Signature: _Chris Serio-Chapman_____

Date: _____

BALTIMORE CITY HEALTH DEPARTMENT
VOLUNTEER SERVICES
REQUEST FOR STAFF

Person Requesting: Chris Serio-Chapman Date: ____/____/____

Bureau or Program: Community Risk Reduction Services

Phone: 443-984-4081

Number of Volunteers 1

Job Title for Volunteer(s) NEP Volunteer

Duties and Responsibilities (please be specific/brief)

- **Volunteers will be permitted to exchange syringes for clients on a 1:1 basis.**
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Skills, knowledge, and abilities needed to perform job: Knowledge of substance abuse, modalities of substance abuse treatment, HIV Prevention, risk reduction interventions, Hepatitis A, B and C

Location where job will be performed: _____

Address: _____

HOURS:

Mon. ____ Tues. ____ Wed. ____ Thur. ____ Fri. ____ Sat. ____ Sun. ____

Start Date: ____/____/____ End Date: ____/____/____

Who will supervise volunteer(s)? Derrick Hunt Title: Program Manager

Phone 410-396-3733

Who will provide training? NEP Staff Title: Health Educators

Phone: 410-396-3733