



Clinica Msr. Oscar A. Romero Community Health Centers

## Philosophy of Volunteer Involvement

Clinica Msr. Oscar A. Romero recognizes and affirms the involvement of volunteers at all levels of the organization as a vital component to achieving its mission: “to provide affordable, quality healthcare, health education, and advocacy to the uninsured and underserved communities of Greater Los Angeles.”

Clinica Msr. Oscar A. Romero encourages the participation of all people regardless of race, ancestry, place of origin, citizenship, creed, sex, sexual orientation, marital status, family status, age, or religious beliefs, in contributing to and building their community. Volunteering at Clinica Msr. Oscar A. Romero is inclusive and open to all who are willing to work within the fundamental values of Clinica Msr. Oscar A. Romero: Professionalism with an emphasis on teamwork, kindness and compassion, Healthcare as a basic right and quality of service at all levels.

Clinica Msr. Oscar A. Romero is committed to supporting and nurturing volunteerism by providing guidance, resources and recognition to all volunteers in a mutually beneficial relationship. We will ensure that volunteers are provided with meaningful assignments, treated fairly as equal co-workers, given effective supervision, offered appropriate involvement and participation, and are regularly recognized for work they do. Volunteers are a *foundational* component of our organization.

**Pico-Union/Westlake:** 123 SOUTH ALVARADO ST., LOS ANGELES, CA 90057. TEL: 213 989-7700, FAX: 213 989-7702  
**Boyle Heights/East Los Angeles:** 2032 MARENGO ST., LOS ANGELES, CA 90033. TEL: 323 987-1030, FAX: 323 221-4528  
**Email:** [developmentinfo@clinaromero.com](mailto:developmentinfo@clinaromero.com) **Website:** [www.clinicaromero.com](http://www.clinicaromero.com)





Clinica Msr. Oscar A. Romero Community Health Centers

## VOLUNTEER APPLICATION

### APLICACION PARA VOLUNTARIOS

PLEASE COMPLETE AND RETURN IT TO THE RECEPTION AND ASK THEM TO FORWARD IT TO THE HUMAN RESOURCES DEPARTMENT.

IF YOU HAVE ANY QUESTIONS IN REGARDS TO THE PROCESS ON SELECTING THE VOLUNTEERS PLASE CALL HUMAN RESOURCES OFFICE AT 213-201-2738 OR YOU CAN SEND AN EMAIL WITH YOUR QUESTIONS TO: [HR@clinaromero.com](mailto:HR@clinaromero.com).

THANK YOU FOR EXPRESSING YOUR INTEREST ON HELPING CLINICA MSR OSCAR A. ROMERO.

UNA VEZ COMPLETA LA FORMA POR FAVOR DE ENTREGARLA A UN REPRESENTANTE DE RECEPCION Y PERDIRLE DE FAVOR QUE LA ENTREGUE AL DEPARTAMENTO DE RECURSOS HUMANOS.

SI TIENE ALGUNA PREGUNTA ACERCA DEL PROCESO DE SELECCION DE VOLUNTARIOS POR FAVOR COMUNICARSE A LOS SIGUINETES NUMEROS DE LA OFICINA DE RECURSOS HUMANOS 213-201-2737 O AL 213-201-2738 O PUEDE MANDAR UN CORREO ELECTRONICO CON SU PREGUNTA A :

[HR@clinaromero.com](mailto:HR@clinaromero.com)

GRACIAS POR SU INTERES EN AYUDAR A CLINICA MSR. OSCAR ROMERO.

Name/Nombre \_\_\_\_\_ Date/Fecha \_\_\_\_\_

DOB/ Fecha de nacimiento, Month/Mes \_\_\_\_\_ Day/Dia \_\_\_\_\_ Year/año \_\_\_\_\_

Telephone#/ Daytime Phone: \_\_\_\_\_ Night/ Noche \_\_\_\_\_

Address/Direccion \_\_\_\_\_

Position/ Title/posición/  
Titulo: \_\_\_\_\_

Area of expertise/ Area de experiencia

Relacionada al trabajo:

Referred by / Referido por:

What other languages do you  
speak? \_\_\_\_\_

¿Que otros idiomas  
habla? \_\_\_\_\_



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## VOLUNTEER APPLICATION APLICACION PARA VOLUNTARIOS

First day of work, month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

***Documents that establish Identity and/or Employment Eligibility-provide copies:***

Identity Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Social Security  
Card# \_\_\_\_\_

Other, Title \_\_\_\_\_ # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Person to Contact in Case of an Emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip code \_\_\_\_\_ Telephone \_\_\_\_\_

Information received from Human Resources On:

\_\_\_\_\_

Language/Lenguaje	Speak/Hablar	Read/Leer	Write/ Escribir	Understand but can't Speak/ Entiendo pero no hablo

When are you available to volunteer?

¿Cuándo esta disponible para hacer trabajo voluntario?

Horario	Lunes	Martes	Miercoles	Jueves	Viernes	Sabado
Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Other Schedule? Please explain

Otro Horario? Favor de

explicar: \_\_\_\_\_

\_\_\_\_\_

Habilidades que puedes ofrecer para ayudarnos:

Skills that you can offer to help us with:



Clínica Msr. Oscar A. Romero Community Health Centers

## VOLUNTEER APPLICATION APLICACION PARA VOLUNTARIOS

	Decoration/ Decoracion (office/ oficina)		Accounting/ Contador
	Translation/ Interpretation/ Traduccion		Outreach/ Trabajo de alcance
	Computer/ Computadoras		Compute Prog/ programacion de Com
	Medical Assistant/ Asistentente Medico		LVN/MED/RN/Doctor
	Health Education/ Consejero de salud		Nutritionist/ Nutricionista
	Maintenance/ Mantenimiento		Filing/ Archivar
	Community Organizing/ Organizacion comunitaria		Constructing/ Construccion
	HIV Testing and Counseling/ Pruebas de VIH		Fundraising/ Campana de recoleccion de fondos
	Receptionist/ Recepcionista		Billing Dept./ Departamento de Cobros

Other:

Otro: \_\_\_\_\_

I am interested in finding out more about the following volunteer areas:

Estoy interesado en conocer mas informacion de otras areas para realizar trabajo voluntario:

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**Please return this to Human Resources:**

**Porfavor de entregar esta forma al departamento de Recursos Humanos:**



## EMERGENCY CONTACTS

Employee: \_\_\_\_\_ Title: \_\_\_\_\_

Employee No: \_\_\_\_\_ Department: \_\_\_\_\_

If you choose, please provide contact information for two individuals whom we can contact in case of an emergency. The two individuals should not reside together. This information will be kept in your confidential personnel file.

### FIRST CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work number: \_\_\_\_\_ Home number: \_\_\_\_\_

Address: \_\_\_\_\_

Other method of contact: \_\_\_\_\_

### SECOND CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work number: \_\_\_\_\_ Home number: \_\_\_\_\_

Address: \_\_\_\_\_

Other method of contact: \_\_\_\_\_

Please sign and date this form below. If any of the above information changes, please let us know.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## CONFLICT OF INTEREST POLICY

I, \_\_\_\_\_ hereby certify that, to the best of my knowledge, no aspect of my current personal or professional circumstances places me in the position of having a private interest which is in conflict with any interest of Clínica Msr Oscar A. Romero or with my obligations to Clínica Msr Oscar A. Romero.

If a conflict of interest should occur in the future, I will inform my supervisor and/or any other management staff of Clínica Msr Oscar A. Romero as deemed necessary.

### **Clinica Msr Oscar A. Romero Definition of Conflict of Interest**

“A conflict of interest, or appearance of one, occurs when you, or a member of your immediate family, or someone with whom you have a close personal relationship use your position with an outside entity for personal benefit through an investment, association, or business relationship that interferes with your ability to exercise independent judgment on behalf of Clínica Msr Oscar A. Romero.”

### **Acknowledgement**

My signature below indicates that I have read and will abide by this policy.

\_\_\_\_\_ Employee    \_\_\_\_\_ Independent Contractor    \_\_\_\_\_ Board Member    \_\_\_\_\_ Volunteer

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



Clinica Msr. Oscar A. Romero  
Employee Acknowledgement of Safely Surrendered Baby Law

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**Purpose:** "The purpose of the Safely Surrendered Baby law is to protect babies from being abandoned by their parents and potentially being hurt or killed."

California's Safely Surrendered Baby Law allows parents to give up their baby confidentially. As long as the baby has not been abused or neglected, parents may give up their newborn without fear of arrest or prosecution.

As a Clinica Msr. Oscar A. Romero employee, I acknowledge receiving information on the California Safely Surrendered Baby Law, which states that, "Every child deserves a chance for a healthy life. For three days after you give birth, you can give up your baby at any Los Angeles County hospital emergency room or fire station. No shame. No blame. No names."

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Employee Acknowledgement Signature

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Date

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Human Resources Signature

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Date



**Subject:**        **Patient's Confidential Information**

**Purpose:**        To protect the disclosure of patient's health information. Under Federal law, the Health Insurance Portability and Accountability Act (HIPAA) places significant restrictions on how individual identifiable health information is handled.

**Policy:**        It is Clinica Msr Oscar A. Romero's policy that the internal business of the organization, particularly information regarding its patients, staff and contractors, is a confidential matter that is to be respected by all employees.

Employees of Clinica Romero shall regard information relating to patients, clients, employees, and contractors in general, written or otherwise, as confidential. Information regarding a patient's or client's medical records, diseases, or other conditions, and personal or family history, must never be communicated to anyone other than a professional and paraprofessional personnel who require such information to treat the patient or client as required by law.

Any information about a patient that is requested by an outside person or for unauthorized purposes will not be released, except by court order, to anyone other than the patient or legal guardian unless the clinic has prior written consent. All such requests must be handled in accordance with the clinic's Medical Record approved policies and procedures. Any employee found to have violated this policy shall immediately be disciplined and may be terminated.

**SIGNED AND AGREED TO BY:**

\_\_\_\_Employee        \_\_\_\_Volunteer        \_\_\_\_Independent Contractor

Signature:\_\_\_\_\_ Date:\_\_\_\_\_

Print Name:\_\_\_\_\_





Clínica Msr. Oscar A. Romero Community Health Centers

## EMPLOYMENT OF RELATIVES POLICY

Date: \_\_\_\_\_

Do you have relatives currently working at Clínica Msr. Oscar A. Romero?

Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer was positive, please provide the name (s) of your relative (s):

\_\_\_\_\_

Department where relatives work:

\_\_\_\_\_

I certify that all information I have provided in order to apply for and secure work with this employer is true, complete and correct.

I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect, will be sufficient cause to (i) eliminate me from further consideration for employment, or (ii) may result in my immediate discharge from the employer's service, whenever it is discovered.

Signature of Applicant

Print Name

\_\_\_\_\_

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**CLINICA MSR OSCAR A ROMERO  
PO BOX 86347, LOS ANGELES, CA 90086**

## **MPN Implementation Notice**

Unless you predesignate a physician or medical group, your new work injuries arising on or after December 26, 2012 will be treated by providers in the State Fund Medical Provider Network. Insert effective date of new MPN If you have an existing injury, you should continue treatment with your current primary treating physician. If you sustain a new work injury, treatment for this injury should be obtained through the State Fund Medical Provider Network. You may obtain more information about the MPN from the workers' compensation poster or from your employer.

I declare under penalty of perjury that I have reviewed and received a copy of the MPN Implementation Notice.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

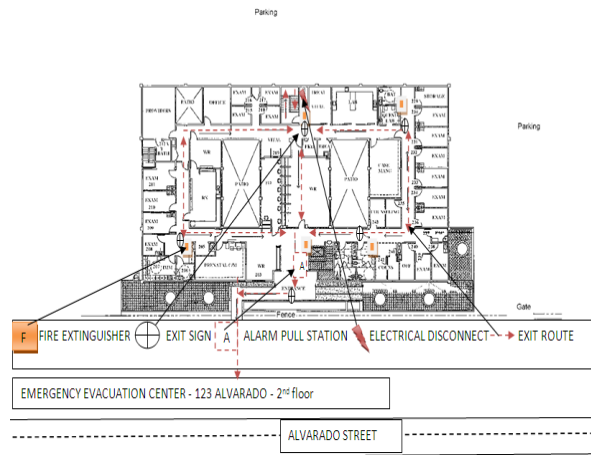
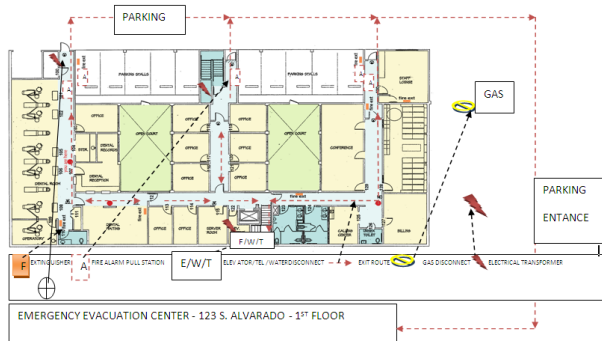


## FACILITY TOUR ACKNOWLEDGMENT

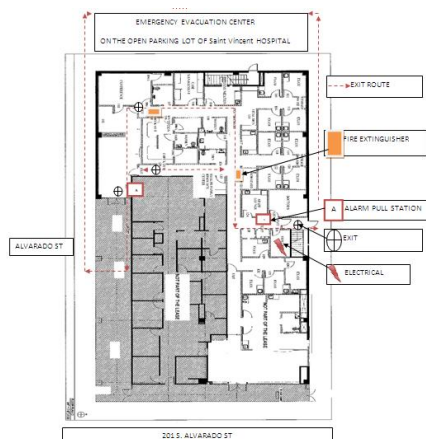
By signing and dating below I acknowledge that I have completed a facility tour and have familiarized myself with the following locations: **Emergency Exits, Fire Extinguishers, and Evacuation Locations.**

### ☐ 123 Alvarado 1<sup>st</sup> & 2<sup>nd</sup> Floor

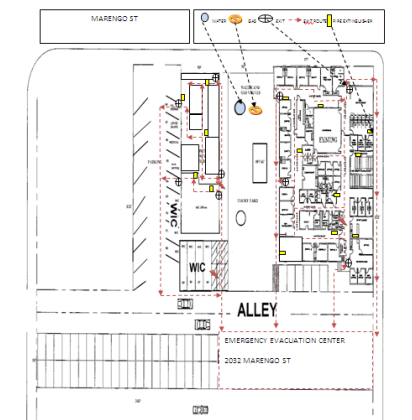
Evacuation Diagrams:



### ☐ 201 Alvarado



### ☐ Marengo



Name of Employee: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_