# Pharmacist Volunteer Application Packet

Dear Prospective Volunteer:

Thank you for expressing an interest in volunteering at Pharmacy of Grace. We take great pride in how successfully our organization is run, but we could not be as productive and effective as we are without the assistance from our amazing **VOLUNTEERS**!

Please direct completed applications to **The Pharmacy of Grace, 721 N. 31st St, Ste 100, Kansas City, Kansas.** You may email your application or drop it off at our front desk. We are glad that you are considering volunteering your time at The Pharmacy of Grace – we assure you that your dedication is greatly appreciated by our staff and patients. You will surely gain an experience unparalleled while working alongside our remarkable staff and other volunteers in our beautiful facilities. We appreciate your interest and look forward to welcoming you to The Pharmacy of Grace team!

If you need additional information, please feel free to contact us at (913) 953-8260 or email us at: info@pharmacyofgrace.org. You can also visit our web site at https://pharmacyofgrace.org/.

Respectfully,

Michael Fink, Pharm.D.
Pharmacist-in-Charge

** Please keep this front page for your reference. **

# Pharmacist Volunteer Application and Agreement Form

Last Name:___________________________ First Name:________________________ Date:___________

Address: _______________________________________________________________________________

City: _____________________________________ State: ________ Zip:______________

Tel:_________________(H) __________________(M) Date of Birth: ____________________

E-mail:__________________________________________________________________________

Kansas License Number: ___________ Years of Experience: __________

Emergency Contact:______________________________________________________________________
(Name) (Tel. No) (Relationship)

Do you have any friends/family who are employed or volunteer here? ___Yes ___No

When are you available to volunteer? (specify hours of availability) _

Weekly: ___ Monthly: _____

Monday ___________ Tuesday __________ Wednesday __________ Thursday _________ Friday __________

Types of volunteer work you think you'd be most comfortable with:

Short Term: ___ Vaccine Event Staff ____ Clean and maintain pharmacy facility

Weekly / Monthly:
- ___ Counseling patients on their medications
- ___ Counseling patients on their medications using a video interpretation service
- ___ Filling medications for patients
- ___ Verifying medications for patients
- ___ Assisting the patient with Rx Local (pharmacy app) setup
- ___ Calling providers for medication changes / dosage adjustments
- ___ Immunization Events

List Your Past Volunteer Experiences:

Organization:_______________________________ Duties:________________________________

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Have you been convicted of a crime? No___ Yes___ If yes, please describe:

How did you hear about our charitable pharmacy?

I need the following accommodation(s) to work as a volunteer:

As a volunteer for Pharmacy of Grace, I agree to abide by all applicable rules and regulations of the agency and the Kansas State Board of Pharmacy. I understand that I will receive no monetary benefits in return for my volunteer service and that Pharmacy of Grace, Inc. may terminate this agreement at any time without prior notice for any reason. I hereby authorize Pharmacy of Grace to check my references.

I certify that my answers on this application are true and complete and that I have not knowingly withheld any information that might, if disclosed, affect my application unfavorably. I understand that any misrepresentation or omission of facts on this application could be cause for rejection of this application or dismissal.

I understand that after I submit my application, it will be reviewed and my eligibility for volunteer work will be determined. I agree to an interview with the on-site manager and on-site orientation to perform my volunteer role.

I hereby Release and Waive liability of Pharmacy of Grace, Inc., a non-profit corporation, its directors, officers, employees, agents, and its successors (the "Released Parties"); for any injuries or illness that I may suffer in connection with any volunteer work for Pharmacy of Grace, Inc. Further, I agree to indemnify, defend, and hold harmless the Released Parties from and against any liability or damage of any kind and from any suits, claims or demands, including legal fees and expenses whether or not in litigation, arising out of, or related to, this volunteer program. I agree that this release is as broad and inclusive as permitted by the laws of the State of Kansas.

I HAVE CAREFULLY READ THIS DOCUMENT AND FULLY UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE, OR GUARANTEE BEING MADE TO ME AND INTEND MY SIGNATURE TO BE COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

Pharmacist Volunteer Print Name | Birth Date

Signature of Pharmacist Volunteer | Date

This release shall remain valid and effective for all Activities engaged in by the Volunteer unless Volunteer revokes the release by providing written notice to Pharmacy of Grace.

# HIPAA VOLUNTEER CONFIDENTIALITY AGREEMENT

I acknowledge that while performing my assigned duties at Pharmacy of Grace I may have access to, use, or disclose confidential health information. I hereby agree to always handle such information in a confidential manner during and after my volunteer opportunity and commit to the following obligations:

A. I will use and disclose confidential health information only in connection with and for the purpose of performing my assigned duties at Pharmacy of Grace.

B. I will request, obtain, or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining, or communicating more confidential health information than is necessary to accomplish my assigned duties at Pharmacy of Grace.

C. I will take reasonable care to properly secure confidential health information on my computer and will take steps to ensure that others cannot view or access such information. When I am away from my workstation or when my tasks are completed, I will log off my computer or use a password-protected screensaver to prevent access by unauthorized users.

D. I will not disclose my personal password(s) to anyone without the express written permission of my supervisor or record or post it in an accessible location and will refrain from performing any tasks using another's password.

I understand that as a **volunteer** of Pharmacy of Grace, the use and disclosure of patient information is governed by the rules and regulations established under **HIPAA**, the Health Insurance Portability and Accountability Act of 1996, and related policies and procedures of the pharmacy. Therefore, regarding patient information, I commit to the following additional obligations:

A. I will use and disclose confidential health information solely in accordance with the federal and pharmacy policies set forth above or elsewhere. I also agree to familiarize myself with any periodic updates or changes to such policies in a timely manner.

B. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to my supervisor.

I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action.

**Volunteer Signature**:______________________________________________________________

Printed Name:____________________________________ Date:________________________________

# Non-Discrimination and Harassment Policy

Pharmacy of Grace and its Board of Directors prohibit discrimination on the basis of race, color, religion, sex, national origin, age, or disability, as well as harassment of employees for any of those reasons. The Pharmacy's non-discrimination policy applies to recruiting, hiring, promotions, compensation, benefits, training, facilities, discipline, and all other terms and conditions of employment. In addition, the Pharmacy will not discriminate against anyone on the basis of any of the reasons cited in providing goods or services to any of its prospective clients.

The Pharmacy of Grace strives to create and maintain a work environment in which people are treated with dignity, decency, and respect. For this reason, the Pharmacy of Grace has a zero-tolerance policy regarding harassment or discrimination of any kind. All individuals, associated with, or employed by, Pharmacy of Grace, are covered by and are expected to comply with this policy. Hereinafter the term "individual" shall mean all persons associated with, or employed by, Pharmacy of Grace. Appropriate disciplinary action will be taken against any individual who violates this policy up to and including termination.

The harassment of any individual because of race, color, gender, sexual orientation, religion, national origin, ancestry, age, marital or parental status, disability or other status protected under state or federal law is strictly prohibited and will not be tolerated.

**Sexual Harassment**

As part of this policy, sexual harassment of any individual is strictly prohibited and will not be tolerated.

Any unwelcome verbal or written comments of a sexual nature (e.g. jokes, innuendos, or slurs), physical conduct (e.g. touching or gesturing), unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature shall be considered sexual harassment which violates this policy and shall subject the offender to appropriate disciplinary action, up to and including termination when:

1. Submission to such conduct is made either explicitly or implicitly a condition of an individual's employment;

2. Submission to or rejection of such conduct by an individual is used as a factor in any decision affecting the individual's employment, including but not limited to any decision related to advancement, performance assessment, compensation, assignments, schedules, discipline, and termination; or

3. Such conduct interferes with an individual's employment or creates an intimidating, hostile, or offensive employment environment.

**Other Forms of Harassment**

It is also the policy of Pharmacy of Grace that any unwelcome verbal or written comments or physical conduct of a hostile or offensive nature based on a person's race, color, religion, sexual orientation, national origin, ancestry, age, marital or parental status, disability, or other status protected under state or federal law shall also be considered harassment which violates this policy and shall subject the offender to appropriate disciplinary action, up to and including termination, when such conduct interferes with an individual's employment or creates an intimidating, hostile, or offensive work environment.

**Procedure for Filing a Complaint of Harassment or Discrimination**

Both employees and volunteers are encouraged to report any violations of this policy to the Executive Director or to the Chair of the Board of Directors. Upon any such violation being reported to the Executive Director, the Executive Director shall immediately report such reported violation to the Board Chair. The Chair, together with the appropriate committee of the Board and the Executive Director, if he/she is not the accused, shall immediately investigate the allegations and take appropriate action. If the allegations prove to be true to the best belief of the Board of Directors, the guilty party or parties shall be subject to disciplinary action, up to and including termination. In the case of a volunteer, that person shall be asked to leave and shall be barred from volunteering at the pharmacy again.

It shall further be the intent of the Pharmacy of Grace and its Board of Directors to comply with all federal, state, and local regulations regarding personnel practices, including all immigration laws.

The Pharmacy of Grace expects all individuals to act responsibly in maintaining a work environment free of harassment and discrimination and will take all appropriate steps to enforce this policy.

**Policy Implementation**

- In addition to having a member of management as the designated staff member to whom complaints of harassment and/or discrimination are to be made, it is important that staff members have an alternate designated staff member(s) to report complaints to in the event the primary contact is identified as the source of harassment.

- Staff members should sign an acknowledgement and receipt form when they receive a copy of the written Harassment Policy. A sample acknowledgment and receipt form are attached.

- In addition to the written policy, staff should also receive meaningful training on the policy, and their rights and responsibilities under the policy. This will also assist in the defense of any outside legal claims.

- All members of your management staff should be advised that they are accountable for the effective administration of this policy and that they may have personal liability for failure to adhere to the policy.

- Once a complaint is received, a fair and impartial investigation of the complaint should begin immediately. These investigations should be conducted as confidentially as possible, on a need-to know basis. You should interview in confidence the employee filing the complaint, as well as the individual(s) against whom the complaint has been filed. Any witnesses to the alleged harassment should also be interviewed in confidence if necessary. The investigation and the results should be fully documented in writing.

- Once the investigation has been completed, if the charge is found to have merit, appropriate disciplinary action should be taken against the employee who violated the policy, up to and including immediate termination of employment based on the severity of the infraction. It is important that disciplinary actions be applied in a consistent manner, and that they be sufficient to stop the harassment and to prevent its recurrence.

Should the investigation indicate that an individual has become the victim of harassment by a third party not employed at the same organization but with which they conduct business, management should take appropriate action dealing with the management of the accused offender to resolve the complaint.

# Non-Discrimination and Harassment Policy Receipt Form

This is to acknowledge that I have received a copy of the Pharmacy of Grace's "Non - Discrimination Policy" and "Harassment Policy", and that I have read and understand the policy.

_____________________________________________ Date: __________________
Pharmacist Volunteer Signature

_______________________________________________________
Pharmacist Volunteer Name Printed

_____________________________________________ Date: __________________
Pharmacist-in-Charge Signature

_______________________________________________________
Pharmacist-in-Charge Name Printed

# Permission to use photograph/video image

I ________________________________, hereby grant to Pharmacy of Grace, the irrevocable and unrestricted right to use including but not limited to copyright, reproduce and publish photograph and video images of me on the pharmacy premises/special events during my period of association with the pharmacy. This form grants Pharmacy of Grace the right to use said images for informational, promotional, and fundraising purposes through any manner or medium (including social media) without limitations or reservations.

This form also grants Pharmacy of Grace permission to publish any testimonial stories I have provided to the organization with the understanding they will only use my first name. I hereby release Pharmacy of Grace, its board of directors, employees, and volunteers from any and all claims, actions and liability relating to the use of said photograph and video images.

__________________________________________________ Date: ________________
**Pharmacist Volunteer Signature**

________________________________________________
**Pharmacist Volunteer Name Printed**

**Address**__________________________________________________________________

**City**______________________ **State**______________ **Zip Code**___________________