Buddhist Tzu Chi Medical Foundation

US Headquarters – www.tzuchimedicalfoundation.org • 10414 Vacco St, South El Monte, CA 91733 • Tel: 626-636-8700 • Fax: 626-636-8737

TIMA USA Membership Application

Chapter/Office:_____ Application Date:_____

Personal Information:

Name:_____ Chinese Name:_____
(Last) (First)

DOB:____/____/_____ (mm/dd/yyyy) Dharma Name:_____ Gender: ☐ Male ☐ Female

Citizenship: ☐ US Citizen ☐ US Residence ☐ Other, please list_____

Address: (o)_____ City_____ State_____ Zip_____

Address: (h)_____ City _____ State_____ Zip_____

Phone: (h)_____ (o)_____ (c)_____ (f)_____

Email Address:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Professional Information:

☐ MD ☐ Dentist ☐ Acupuncturist ☐ Pharmacist
☐ NP/PA ☐ RN/LVN ☐ Dental Assistant ☐ Dietitian/Nutritionist
☐ Physical Therapist ☐ Other: _____
Specialty: _____

Status: ☐ Active Practice ☐ Retired(1) ☐ Self-employed(1) ☐ Other(1), please explain:_____
☐ Employed, Employer(2):_____ Contact(2):_____ Phone(2):_____

Note: (1) Please Provide Evidence of Health Clearance, form attached; (2) For Proof of Health Clearance Purpose.

Professional License Number and Type:_____ Exp. Date:_____

NPI #:_____ **DEA # (if applicable):**_____ Exp. Date:_____

Certifications:

Certified by American Board of _____ Exp Date:_____

Language:	Listen –	Speak –	Read –	Write –
English	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some
Spanish	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some
Chinese (Mandarin)	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some
Chinese (Cantonese)	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some
Other: _____	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some	☐Fluent ☐Some

Tzu Chi Roles:

☐ Member ☐ Volunteer ☐ Commissioner in Training
☐ Commissioner ☐ Tzu Cheng ☐ Honorary Board Member ☐ Other _____

Volunteer Interests:

☐ Community Tzu Chi Activities ☐ Free/Community Clinic ☐ Outreach/Consultation Missions
☐ Patient Support Group ☐ Volunteer Training ☐ Health Education Speaker
☐ Bone Marrow Stem Cell Donation Promotion ☐ International Medical Missions
☐ Emergency Disaster Relief ☐ Other _____

References:
Please provide one professional reference whom we may contact:
Name: _____ Daytime Phone: _____ Relationship: _____
How long have you known this person? _____

Tzu Chi TIMA Mentor:
Name: _____ Daytime Phone: _____ Relationship: _____

Professional Liability:
Tzu Chi Medical Foundation covers malpractice insurance for volunteers during the practice in Tzu Chi related activities. The carrier is Norcal Mutual Insurance Company.

If answer to any of the following is "Yes", please provide full details on separate sheet of paper.

1. ☐ Yes ☐ No Has your license to practice in any jurisdiction ever been limited, suspended or revoked?
2. ☐ Yes ☐ No Have your privileges at any medical/dental facility ever been suspended, diminished, revoked or not renewed?
3. ☐ Yes ☐ No Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any Medical/dental organization?
4. ☐ Yes ☐ No Have you ever had or do you presently have a substance abuse problem that would impair in any manner your ability to deliver care and maintain good public relations with patients, other staff, and other providers in the clinic?
5. ☐ Yes ☐ No Has your D.E.A. or Furnishing Certificate ever been denied, suspended, or refused?
6. ☐ Yes ☐ No Have you ever been convicted of a felony?
7. ☐ Yes ☐ No Has malpractice insurance ever been denied, cancelled or renewal refused?
8. ☐ Yes ☐ No Have judgments or settlements been made against you in professional liability cases or are there any pending? If "Yes" give details on a separate sheet.
9. ☐ Yes ☐ No Do any health problems exist that would hinder your ability to practice effectively?
10. ☐ Yes ☐ No Are you being required to volunteer or do community service by any agency?
11. ☐ Yes ☐ No Do any sanctions prevent you from participating in Medi-Cal or Medicare billing?
12. ☐ Yes ☐ No Are there any mental or physical health impairments that would affect your ability to perform any of your duties, with or without reasonable accommodation, according to accepted standards of professional performance?

Mission Statement:

The Mission of the Tzu Chi Medical Foundation is to provide free primary healthcare services to individuals who lack access to care, through a culturally diverse, volunteer-based organization with emphasis on education and community outreach.

Agreement:

I have read and support the mission of Tzu Chi Medical Foundation. The foundation is a non-profit, community based, volunteer driven organization committed to provide health related events to community members regardless of their age, sex, race or religion.

I agree to maintain strict patient confidentiality in my position as a volunteer.

I consent to the use of my photograph for any media as it pertains to the Medical Foundation or Tzu Chi Foundation program.

I hereby authorize any or all of the employers and/or schools I have worked for and/or attended to furnish Tzu Chi Medical Foundation with any information they may have concerning my records or me. I hereby release employers, schools and individuals from all liability in furnishing this information.

I hereby authorize Tzu Chi Medical Foundation to further search the files and records of the justice system for any criminal history information. I understand that the results of such an investigation shall remain confidential, but shall be reviewed by Tzu Chi Medical Foundation to determine my suitability for employment/volunteer.

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of service, he/she (the undersigned) will immediately notify the Tzu Chi Medical Foundation. The undersigned understands that the Tzu Chi Medical Foundation reserves the right to decline or dismiss a volunteer physician/nurse practitioner for just cause or reason.

ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Applicant's Signature: _____ **Date:** _____

Physical Evaluation

Applicant's Name: _____ Date of Birth: _____
Last First (mm/dd/yyyy)

I authorize the undersigned Physician to release the following medical information to Buddhist Tzu Chi Medical Foundation.

Applicant's Signature: _____ Date Signed: _____

Indicate with "X" any evidence of the following, to be completed by a physician

___ Any previous surgery
___ Back or Discogenic Disease
___ Cardiovascular Disease
___ Congestive Heart Failure
___ Renal, Liver, Glandular Disorder
___ Recurrent Skin Infections
___ Sexual Transmitted Disease (STD)
___ Any medical illness
___ Diabetes Mellitus
___ High blood Pressure
___ Infectious Disease
___ Orthopedic Problem
___ Glasses/Contact Lenses
___ Any allergy
___ Arthritis
___ Angina
___ Seizure
___ Vertigo
___ Fainting Spells
___ Unstable Knees
___ Current Medication(s): _____
___ Other Serious Illness: _____

Evidence that volunteer/employee is free from tuberculosis is mandatory: A negative Tuberculin test within one year is sufficient. Positive reaction to the skin test shall be followed by a 35.55cmx43.18cm (14" x 17") chest x-ray. No evidence of tuberculosis infection screening within 12 months is required.

A. **Tuberculin Test**

Date	Injection side	Initial	Reading Date	Check	Induration	Erythema	Initial
				Positive Negative			

B. **Chest x-Ray Result**: _____ Date: _____

Recommendation:
The Person named above, has completed physical examination which revealed general physical condition and his/her suitability as a volunteer is listed as follows.

___ Yes, the person may volunteer without restrictions.
___ Yes, the person may volunteer with restrictions noted below.
___ No, the person should not be scheduled as a volunteer.

Remarks: _____

Physician's Signature: _____ Date Signed: _____

Physician's Printed Name: _____ Phone: _____
(Medical Office Stamp is preferred)

Hepatitis B Vaccine Declination

I understand that, due to my occupational exposure to blood and other potentially infectious materials; I may be at risk of exposure and acquiring the Hepatitis B Virus.

I have been given the opportunity to be vaccinated with Hepatitis B vaccine at cost to myself.

However, I decline Hepatitis B vaccination at this time. I understand by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease.

If, in the future, I continue to have exposure to blood or other infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at charge to me.

I have been vaccinated on _____

I had my blood tested on hepatitis B, and the result was
HBs Ag___ Hbs Ab _____HBc Ab_____.

_____ _____
Applicant's Signature Date Signed

_____
Applicant's Printed Name

This form will be completed if an employee/volunteer decides to decline the Hepatitis B vaccination. Buddhist Tzu Chi Medical Foundation will retain the completed form in the employee's/volunteer's file for the length of employment/volunteering plus thirty years.

Media Privacy Statement

I, _____, (Guest) hereby give permission to the Buddhist Tzu Chi Medical Foundation, (Tzu Chi) to interview me and to take my picture(s) or videotape(s), and/or to write articles about me. The Personally Identifiable Information includes any information that personally identifies which can be the first and last name, telephone number and address.

I further verbally grant Tzu Chi the use of this (these) photograph(s), videotape(s) and/or articles in its newsletter, promotional materials, web sites, and/or advertisement for Tzu Chi and its affiliate, without any compensation to me.

I hereby release any and all rights, titles, and interests to and in said photograph(s), videotape(s) and/or articles to Tzu Chi.

I hereby understand that my personally identifiable information that I have submitted to Tzu Chi in the past and then have second thoughts or want to update it, I have being advised to send the request to:

Legal Department
Buddhist Tzu Chi Medical Foundation
1000 S. Garfield Avenue, Alhambra, CA 91801

I hereby authorize _____ as my attorney-in-fact to sign any release liability document to Tzu Chi on my behalf.

Tzu Chi takes your respect privacy seriously. Questions regarding this statement or our practices should be directed to the Tzu Chi Legal Department by email at Peter.Chiu@us.tzuchi.org. You may also send inquiries by mail to:

Legal Department
Buddhist Tzu Chi Medical Foundation
1000 S. Garfield Avenue, Alhambra, CA 91801

Security of Private Information

Any personal information you give us is kept in secure files. Access is limited to the few employees who have a need to know.

We reserve the right to change our policy from time to time, as we deem appropriate in our sole discretion.

Authorized by: _____ _____
Guest's Signature Date

Print Guest Name: _____ _____ _____
First Name Last Name Chinese Name

Witness by: _____ _____ _____
Name Date Location

Confidentiality Statement

CONFIDENTIALITY OF PATIENT INFORMATION

As a volunteer of Buddhist Tzu Chi Medical Foundation, I understand that in my capacity as a volunteer with Buddhist Tzu Chi Free Clinic, I may come into contact with confidential information. I agree to protect this information to the best of my ability and not to divulge it during my volunteer service or after my volunteer service has ended.

Signature _____

Print Name _____

Date _____

Witness _____

WAIVER AND RELEASE OF LIABILITY AND AGREEMENT TO VOLUNTEER AT TZU CHI

In consideration of being accepted to volunteer in any way as a Loving Sister/Brother of the TZU CHI affiliates, in any field trip, class, seminars, lecture, meeting, performance, practice, clinic, tournament, visitation to charity, and related events of the **Tzu Chi Medical Foundation** I hereby:

1. Agree that, prior to undertaking any volunteer obligation, I will evaluate the risks involved in such activity, including driving and traveling to and from class, and if I believe anything is unsafe of beyond my capability or risk tolerance, I will immediately advise my supervisor and refuse to participate.

2. Acknowledge and fully understand that I will be engaging in guiding of all age and supervising their activities during Tzu Chi sponsored event that sometimes might result in injury and severe social and economic losses due not only to my own actions, inactions, or negligence, but also to the actions, inactions, or negligence of others, the policies of Tzu Chi, conditions of the premises or of any equipment used. Further, I acknowledge that there may be other risks not known to me or not reasonably foreseeable at this time.

3. Knowing the risks involved acting as a Loving Brother/Sister, I assume all such risks and accept personal responsibility for the damages following such injury, and consent to Tzu Chi seeking for myself whatever medical assistance it may deem necessary for my interest in the event of an emergency.

4. Release, waive, discharge and covenant not to sue **Buddhist Tzu Chi Foundation, U.S.A., and Tzu Chi Medical Foundation,** together with their affiliated clubs, their respective administrators, directors, agents, teachers, Loving Mom/Dad, coaches, and other employees or volunteers of the organization, event officials, medical personnel, other participants, their parents, guardians, supervisors and sponsoring agencies, sponsors, advertisers, and if applicable, owners, lessors and lessees of premises used in conducting the event,
all of whom are hereinafter referred to as "releasee", from any and all claims, demands, losses, or damages on account of injury, including permanent disability and death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise to the fullest extent permitted by law.

I HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I GIVE UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND KNOWING THIS, SIGN IT VOLUNTARILY. I AGREE TO PARTICIPATE KNOWING THE RISKS AND CONDITIONS INVOLVED AND DO SO ENTIRELY OF MY OWN FREE WILL. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENT/GUARDIAN AS EVIDENCED BY THEIR SIGNATURE BELOW.

_____	_____	_____
Name of Volunteer	Volunteer's Signature	Date
_____	_____	_____
Name of Witness	Witness's Signature	Date

FOR PARENTS/GUARDIANS OF VOLUNTEERS OF MINORITY AGE
(UNDER AGE 18 AT TIME OF APPLICATION)

This is to certify that I, as parent/guardian with legal responsibility for this volunteer, do consent and agree to his/her release, as provided above, of all the Releases, and, for myself, my heirs, assigns, and next of kin, I release and agree to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in these programs as provided above, even if arising from their negligence, to the fullest extent permitted by law. I have instructed the minor volunteer as to the above waiver and conditions and their ramifications. In the event of emergency, I hereby consent to Tzu Chi seeking for this volunteer whatever medical assistance deemed necessary by Tzu Chi for his/or interest.

_____	_____	_____
Parent/Guardian (print)	Parent/Guardian's Signature	Date