MERCY DENTAL MISSIONS STUDENT SHADOW/VOLUNTEER PROGRAM

Mercy Dental Missions is excited to offer the Student Shadow/Volunteer Program for students and pre-dental students interested in gaining practical experience through shadowing. This program will allow students to observe dental professionals and engage with the Mercy Dental team while also learning valuable skills and insights about dental care, in a non profit setting reaching the underserved.

Each semester we will have approximately 4-6 weekly recurring opportunities for students. When these spots fill, we will still have single volunteer opportunities for additional students, so please don't hesitate to apply.

PROGRAM OVERVIEW:

1. **Pre-Application**
    - Read through our website at www.mercydentalmissions.org
    - Review our social media platforms *(Facebook, Instagram, LinkedIn)*
2. **Application Process**
    - Students must submit an application.
    - Applications will be reviewed, and selected candidates will be invited for an in-person interview with the Executive Director.
3. **Clinic Tour and In-Person Interview**
    - Learn about our mission, programs, history, and our future.
    - During the interview, the student will have the opportunity to meet the Executive Director, and some of the clinical team members.
    - Students will be given a tour of the clinic and meet the staff.
4. **Signing Up for Shadowing Days**
    - Students will need to sign up for their selected spots
    - Sign up dates are not confirmed until the Programs Coordinator confirms.
5. **First Day of Shadowing**
    - Students will fill out the following forms on their first day:
        - Release of liability
        - Photo Release Form
        - HIPAA Privacy and Security Agreement Form

- Students will receive education on clinical safety and patient privacy/confidentiality laws (two training videos in house).
    - OSHA Training - https://www.youtube.com/watch?v=iLWkqA_2sNg
    - If Saliva Were Red - https://www.youtube.com/watch?v=68MBFYMjTe4

6. **Check-In After Approximately Five Shadowing Days**
    - Students will meet with the Executive Director for a short checkpoint to assess progress and provide feedback.
7. **Fundraising Opportunity**
    - During the students' shadowing time period, they will have an opportunity to fundraise and to gain awareness of Mercy Dental Missions through their own personal experience and connections.
    - If the student has someone who is interested in donating or volunteering, they should direct them to our website.
8. **Post Completion of Shadowing Experience**
    - After shadowing, students will be sent a survey to complete.

APPLICATION FORM FOR STUDENT SHADOWING/VOLUNTEER PROGRAM:

PERSONAL INFORMATION:

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ DOB: ____/_____/_____

Email: _____

Please list any languages you speak fluently: _____

Any food allergies? ☐ Yes ☐ No *If yes, please list:* _____

University/College Name: _____

Current Year (Fr, So, Jr, Sr): _____

Current Education Level (Pre-Dental, Undergrad, etc.): _____

School Major Advisor Contact Name: _____

Phone: _____ Email: _____

WHY ARE YOU INTERESTED IN THE MERCY DENTAL MISSIONS STUDENT SHADOWING/VOLUNTEER PROGRAM?

_____

_____

_____

_____

HAVE YOU HAD ANY PREVIOUS EXPERIENCE, SHADOWING, OR VOLUNTEERING IN THE DENTAL FIELD? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

_____

PLEASE LIST ANY RELEVANT SKILLS, EXPERIENCE, OR COURSEWORK THAT YOU BELIEVE WOULD BE HELPFUL FOR YOUR SHADOWING ROLE:

_____

_____

_____

_____

AVAILABLE DAYS AND TIMES FOR SHADOWING:

Please list your availability *(MDM is open M-Th from 8:00AM - 5:00PM)*:

Monday: ☐ Yes ☐ No | _____AM/PM - _____AM/PM **AND/OR** _____AM/PM - _____AM/PM

Tuesday: ☐ Yes ☐ No | _____AM/PM - _____AM/PM **AND/OR** _____AM/PM - _____AM/PM

Wednesday: ☐ Yes ☐ No | _____AM/PM - _____AM/PM **AND/OR** _____AM/PM - _____AM/PM

Thursday: ☐ Yes ☐ No | _____AM/PM - _____AM/PM **AND/OR** _____AM/PM - _____AM/PM

DO YOU HAVE MEDICAL INSURANCE? ☐ Yes ☐ No Policy Number: _____

Physicians Name: _____ Clinic/Hospital: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact First Name: _____ Last Name: _____

Relationship to You: _____ Phone Number: _____

AGREEMENT & LIABILITY WAIVER:

By signing below, I confirm that the information provided is accurate, and I understand that participating with Mercy Dental Missions as a student shadowing/volunteering may require further screenings or training as part of the process.

I acknowledge that an electronic signature on this document carries the same weight and legal significance as a handwritten signature.

I also agree to release and hold harmless Mercy Dental Missions, its affiliates, staff, and students from any and all liability for injury, illness, loss, or damage that may occur during or as a result of my shadowing/volunteering participation.

Printed Name of Applicant: _____

Signature of Applicant: _____

Date: _____/_____/_____

PHOTO & VIDEO RELEASE AGREEMENT:

I hereby grant Mercy Dental Missions permission to use my photography, video likeness, and/or any interviews with me in any and all of its publications, promotional materials, websites, social media, and fundraising efforts, without payment or other consideration.

I understand that these materials may be shared publicly and used for promotional, educational, or fundraising purposes. I waive any right to inspect or approve the finished product in which my likeness appears.

I also release Mercy Dental Missions and its representatives from any claims, damages, or liability arising from the use of these materials.

☐ I AGREE to the terms of this photo/video release

☐ I DO NOT AGREE to the use of my photos or videos for promotional purposes

Printed Name: _____

Signature: _____

Date: _____/_____/_____

HIPAA PRIVACY AND SECURITY AGREEMENT FORM:

As a shadow/volunteer in the Mercy Dental Missions Student Shadow/Volunteer Program, I understand the importance of patient privacy and confidentiality. I agree to the following terms:

1. I will not share, disclose, or discuss any patient information with anyone outside the clinic, except as required for medical purposes or as directed by my supervisor.
2. I will respect all patient records, whether in paper or electronic form, and will ensure that such records are kept secure.
3. I will not use or access patient information for personal purposes.
4. I will follow all policies and procedures set forth by Mercy Dental Missions regarding patient privacy and confidentiality.

By signing this form, I acknowledge that I have been educated on HIPAA guidelines and I agree to adhere to them throughout my participation in the program.

Printed Name: _____

Signature: _____

Date: _____/_____/_____