NEW MEXICO DEPARTMENT OF HEALTH
VOLUNTEER AGREEMENT

Scope of Volunteer Services

I, _____
Printed name of Volunteer

agree to perform the following services on behalf of the New Mexico Department of Health (DOH), without compensation as requested and authorized by DOH:

Participate as a volunteer at SKIIP clinics
SKIIP = School Kids Influenza Immunization Program

Qualifications – I will be providing the above Volunteer Services as a:

_____ Licensed Health Care Provider Volunteer
_____ Non-Licensed Medically Trained Volunteer
_____ Lay Volunteer (no medical training)

Assigned Location/Supervisor – I will provide the above-described Volunteer Services at the following location:

Various SKIIP clinics in the NMDOH Metro Region
Name and Address of DOH Assignment

under the supervision of **Erica Martinez-Lovato, Immunization Program Mgr.**.
Name and Title of DOH Supervisor

Period of Agreement – This Volunteer Agreement will begin on **9/1/2018** and will continue until **9/1/2019**, or until terminated by me or at the discretion of my DOH Supervisor and DOH.

Supervision and Training – I agree to follow all supervisory directives from my designated DOH Supervisor, to be subject to DOH quality and improvement oversight as applicable, to attend orientations and trainings as requested by DOH (Including Health Insurance Portability and Accountability Act of 1996 or "HIPAA" training, if applicable, or all other applicable training provided by DOH), and to comply with all applicable DOH policies and professional/ethical standards.

Volunteer Status/Benefits – I confirm that I am not an employee of DOH and am not entitled to any employment benefits that DOH offers (e.g., sick or vacation leave, retirement benefits, insurance, etc.). I understand that I am only entitled to benefits under the New Mexico Workers

Compensation Act[1] if I am an unpaid health care professional deployed by DOH within the state in response to a governor "declared" public emergency, or deployed by DOH outside the state in response to a request for emergency health professional made pursuant to the Emergency Management Assistance Compact.[2] I also understand that, as an unpaid volunteer acting on the behalf or in the service of DOH performing the above-described Volunteer Services as requested, required or authorized by DOH, I am entitled to the liability protections of the New Mexico Tort Claims Act.[3]

Confidentiality, Privacy and Security of Identifiers and Health Information – The Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), all applicable regulations thereto, protect the confidentiality, privacy and security of individual health information.

New Mexico law also provides privacy protection for certain individuals and their information. The "files and records of the department giving identifying information about individuals who have received or are receiving from the department treatment, diagnostic services or preventive care for diseases, disabilities or physical injuries, are confidential and are not open to inspection except where permitted by rule by the department"[4] Additionally, "all health information that relates to and identifies specific individuals as patients is strictly confidential and shall not be a matter of public record or accessible to the public.[5]

I acknowledge that I must protect the confidentiality, privacy and security of all DOH patients, clients, residents or consumers and their health information and records that I obtain from the DOH, and that I shall not disclose such information or records to or discuss the condition of any such individuals with any person except those persons to which such disclosure is necessary to the performance of my assigned duties and responsibilities as a Volunteer. I understand that a breach of confidentiality may result in monetary liability, civil or criminal penalties imposed by law.

Affirmation and Signature – I affirm that I have read and understood the contents of this Volunteer Agreement and have been given an opportunity to clarify any information contained within the Agreement that I did not understand. I agree to abide by all terms of this Agreement. I further affirm that I have not been convicted of a felony.

Signature of Volunteer	Date
New Mexico Department of Health Representative	Date

Needed for HIPAA access: Last Four Digits of Social Security Number _____

1 §12-10-14, NMSA (1978); § 52-1-3.1, NMSA (1978)
2 §12-10-14, NMSA (1978); § 52-1-3.1, NMSA (1978)
3 §41-4-1, et seq., NMSA (1978)
4 §24-1-20(A) NMSA (1978)
5 §14-6-1(A) NMSA (1978)