

**Angels Community Clinic
Volunteer Application**

Name _____
(Last) (First) (Middle)

Address _____
(Street) (City) (State) (Zip Code)

Social Security Number _____ Date of Birth (optional) _____

Home Phone _____ Number where you can be reached during the day _____

Have you ever been convicted of a crime? _____ If yes, describe _____

Occupation _____ Employer _____

Previous or Present Volunteer Experience _____

Special Hobbies or Skills _____

How did you hear of Angels Community Clinic? _____

Person to be notified in case of an accident or emergency:
Name _____ Phone Number _____ Relationship _____

References

Name/Occupation	Address	Phone Number
1.		
2.		

If a license and/or proof of certification is required to practice, you are required to bring copies of license and/or certification and keep the clinic updated of renewals and changes. If you have liability coverage, you are required to bring this also.

Please note: Volunteers are required to have a yearly TB skin test on file. It can be a copy.

APPLICANTS CERTIFICATION AND AGREEMENT

I hereby certify that the facts set forth in the above application are true and complete. I understand that falsified statements shall be considered sufficient cause for dismissal.

(Signature) (Date)

ANGELS COMMUNITY CLINIC VOLUNTEER OPPORTUNITIES

Please check the volunteer opportunities pertaining to you:
(You may indicate more than one opportunity)

_____ Administrative/ Clerical

1. Greeters
2. Loggers
3. Filers
4. Computers
5. Mailings
6. Office Support

_____ Advanced Registered Nurse Practitioner

_____ Housekeeping

_____ Interviewer

_____ Licensed Practical Nurse

_____ Nursing Assistant

_____ Pharmacist

_____ Phlebotomist

_____ Physician

_____ Physician Assistant

_____ Registered Nurse

_____ Yard Work

It is our wish to create a position that you enjoy...that you find exciting...and worthy of your valuable time.

If there is something you like to do, but we do not have it listed above, please use the remainder of the space to help us find the best volunteer position for you.

Please indicate the best days and times for you to volunteer. The Clinic will be open to patients on Tuesday evening from 5:00 – 8:00 p.m. In addition, volunteers are greatly needed at other times for office support.

Preferred Times: (please indicated morning, afternoon, or evening)

_____ Monday _____ Tuesday _____ Wednesday
_____ Tuesday _____ Thursday _____ Saturday

How many hours per week would you like to volunteer? _____ per month? _____ per quarter?

CONFIDENTIALITY STATEMENT

All information pertaining to patients, medical records, reports and personnel records is strictly confidential.

Any employee or volunteer found reading records, discussing patient information or sharing confidential information without explicit authorization to do so shall be subject to immediate dismissal.

I, _____, understand the above and agree to respect and keep confidential all information I may hear or read pertaining to patients, medical records or staff personnel records.

Signature

Date

Records of Training and Experience
Angels Community Clinic

1. Educational Background
(Schools attended and Years, Degrees Obtained)

2. Previous Work-Related Experience

3. Additional Training or Experience