



VOLUNTEER APPLICATION

___Dr. ___Mr. ___Mrs. ___Ms.

Date of Application: ___/___/___

Frist Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone Number: _____ Email: _____

Date of Birth: ___/___/___

Education (circle highest completed): High School – 1 2 3 4 College – 1 2 3 4 Post Graduate – 1 2 3 4

If you are currently a student, where are you enrolled? _____

If you are currently employed, please list name of employer and job title: _____

Volunteer area of preference: _____

Can you commit to volunteering for at least 3 months? ___ Yes ___ No

Hours and days available to work: _____

Please state your reasons for wanting to volunteer at Healing Hands. Are you fulfilling any kind of community service hours, or school requirements? _____

Limitations related to health: _____

Please list any previous volunteer experience, including dates:

Please give any other information you feel would be pertinent to your application: _____

If applicable, check certification: MD___ NP___ RN___ LPN___ RMA___ CNA/CMA___ OD___

DDS___ Hygienist___ RDA___ Chiropractic Care___ Other_____

License number _____ State _____ Exp date _____

DEA # _____

(Please attach copies of licensure).



Church Affiliation: _____

Have you ever been convicted of a felony or crime? ____ Yes ____ No

If yes, please explain: _____

In case of emergency contact: _____ Phone: _____

Relationship of contact: _____

Please indicate interests/skills you would be willing to share as a volunteer:

- | | |
|----------------------|---|
| Clerical skills | <input type="checkbox"/> typing <input type="checkbox"/> filing <input type="checkbox"/> receptionist <input type="checkbox"/> using copier <input type="checkbox"/> filing
<input type="checkbox"/> mailings <input type="checkbox"/> computer <input type="checkbox"/> other, specify _____ |
| Communication skills | <input type="checkbox"/> public speaking <input type="checkbox"/> grant writing <input type="checkbox"/> sign language
<input type="checkbox"/> foreign languages _____
<input type="checkbox"/> fundraising <input type="checkbox"/> volunteer recruiting <input type="checkbox"/> public relations
<input type="checkbox"/> other, specify _____ |
| Spiritual services | <input type="checkbox"/> Spiritual Friend (provides spiritual services to patients) |

Healing Hands Health Center recommends immunization against Influenza, Measles, Hepatitis B, Mumps, Rubella, and Varicella Zoster.

- I have had the recommended immunizations.
- I am aware of the risk of exposure and choose not to have the recommended immunizations.

By signing this application, I agree to treat both patient and/or staff records as highly confidential. I will not discuss or disclose any information which I hear, see, read or otherwise acquire except what is appropriate to discuss with center staff in a private setting. I agree that I render these health care services voluntarily, without compensation or the expectation or promise of compensation. This acknowledgement and agreement has been made before rendering any services.

I have been advised to review the Healing Hands Health Center Volunteer Management Policies. I agree to report to the appropriate persons any incidents or injuries in which I am involved with during my volunteer service. I understand that my service as a volunteer is covered up to the limits specified by the center's insurance program and I hereby waive any claim against the center except as specified herein.

I certify that the statements I have made in this application are true and accurate.

Signature of applicant

Date

For office use only

Orientation date: ____/____/____ Clinic & position _____