………………………………………………………………………… **FOR OFFICE USE ONLY**…………………………………………………………………………………

Date Received: _______
Orientation Date: _______
Start/Shadow Date: _______

Information Updates:
Volunteer Contact List: __________
Email/Distribution List: __________

Volunteer Type: __________
Processed By: ____________

****

VOLUNTEER APPLICATION

We consider applicants for all volunteer positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

****

Personal Information:

Date: ___________________

Name: ____ Birthdate: _______________

Address: ____

City: ___________________________ State: __________ Zip Code: _____________________

Employer: ____ Work Phone: _________________________

Home Phone: ______________________________________ Cell Phone: ___________________________

Email Address: ____

****

Volunteer Services:

Please mark "X" in the area in which you are licensed (1-8) or have an interest (9-12):

1. _____ Physician (MD,DO)
2. _____ Nurse Practitioner (FNP, PNP)
3. _____ Physician Assistant (PA)
4. _____ Nurse (RN, LVN, CNA)
5. _____ Pharmacist (RPh)
6. _____ Pharmacy Technician
7. _____ Certified Medical Assistant (CMA)
8. _____ Other: ___________________________
9. _____ Spanish Interpreter
10. _____ Intern
11. _____ Patient Registration/Screener
12. _____ Daytime Projects (clerical)

****Health Care Professionals** (1-8) must be licensed and/or certified in the state of Texas to practice at the Clinic.*
Please provide the following information:

Occupation / Specialty: ____

Medical License # / Certification: ___________________________________Expiration Date _____________________

Last four (4) digits of Social Security Number: _____________________

Health Care Professionals: Do you have privileges at any local hospital(s)? Yes or No

If Yes, which one(s): ____

****

Schedule Preferences:

Preferred clinic night: Monday _____ Tuesday Morning Clinic: _____ Thursday _____

How often? 1x Month _____ 2x Month _____

Language Skills:

Please indicate which languages you are fluent (F) or can communicate (C):

Spanish _____ Chinese _____ Japanese _____ Korean _____ Other: _____________________

****

Volunteer Experience / Goals:

Have you volunteered elsewhere? If so, where? ____
____

What are reason(s) for wanting to volunteer at the Greater Killeen Free Clinic? _________________________________
____
____

What do you hope to achieve from your volunteer experience? ____
____

How did you hear about us? ____
____

****

References:

1.) Name: ____ Phone: _________________________

2.) Name: ____ Phone: _________________________

****

Conviction Record Statement:

Have you ever been convicted of, or received deferred adjudication for, a crime? Yes _____ No _________

If yes, please explain: ____

****

Agreement:

I (print full name) ____ authorize any inquiry to be made on any information contained in this application if I am considered for volunteer placement which could include a background check. I agree to all terms of the Volunteer Orientation and Standards, including Standards of Dress and Privacy Policies. I am willing to serve at a minimum of six (6) months after my on the job training. I understand I will serve two (2) three (3) hour shifts a month unless my duty assignment calls for a different schedule. I understand that all files and records maintained by the Greater Killeen Free Clinic are privileged and confidential. Any and all information that I may have access to may not be released or communicated to others unless authorized by the Executive Director or staff member who has also been authorized by the Executive Director to make that determination. I understand that I will be expected to treat all patients, volunteers and staff with respect. I understand and consent that any photos or video taken of me while at the Clinic can be used for Clinic purposes. I acknowledge my understanding of the conditions of my voluntary service for the Greater Killeen Free Clinic and acknowledge and understand that I must conform to the rules and regulations of the Greater Killeen Free Clinic to the best of my ability or my voluntary services may be terminated.

Signature: ____ **Date:** _______________________