free medical clinic
of Northern Shenandoah Valley, Inc.

VOLUNTEER SERVICE APPLICATION

Date:_____

Name: (Please Print)_____

Address:_____

City/State/Zip:_____

Home Phone #:_____ **Work Phone #:**_____ **Birthday:** _____/_____
Month/Day

Cell phone #:_____ **Email address:** _____

Occupation:_____ **Employer:**_____

PROFESSIONAL LICENSE NUMBER: _____ **Expires:** _____

Education and/or special training:_____

_____

List volunteer work you have been engaged in or are currently doing (affiliations with other non profit organizations):_____

_____

List some responsibilities you had/have in these organizations:_____

_____

Why are you interested in volunteering for the Free Medical Clinic?_____

_____

Do you have any physical limitations or medical problems that might restrict your volunteer activities? ☐ **Yes** ☐ **No**

How often would you be able to volunteer? ☐ **Weekly** ☐ **Twice monthly** ☐ **Monthly** ☐ **Other** _____

What hours would you be able to volunteer?_____

If necessary, would you be able to volunteer on short notice? ☐ **No** ☐ **Yes – How much notice would you need?**_____

ASSIGNMENT PREFERENCES:

☐ **Clerical**	☐ **Dental Assistant**	☐ **Event Volunteer**	☐ **Dentist**
☐ **Interpreter**	☐ **Nurse**	☐ **Patient Education**	☐ **Pharmacist**
☐ **Pharmacy Technician**	☐ **Physician**	☐ **Receptionist**	☐ **Screener**

301 North Cameron Street, Suite 100, Winchester, Virginia 22601
(540) 536-1680 / Fax: (540) 662-3153

Please list two people who would serve as references for you (non-relatives):

Name _____ Phone # _____

Name _____ Phone # _____

How did you learn about the Free Medical Clinic? ☐ **Radio** ☐ **Television** ☐ **Newspaper** ☐ **Friend**

☐ **Other Organization** ☐ **Board Member** ☐ **Other** _____

Volunteer Manual will be provided including Volunteer Code of Conduct.

Confidentiality

We will honor the confidentiality of patients, volunteers, sponsors and donors and adhere to the established precepts of confidentiality of Free Medical Clinic's Policies & Procedures. We agree to consider information pertaining to social and medical conditions, family situations, and other facts of a highly personal nature as confidential and therefore we understand that we are not to disclose this information to any person who is not authorized by the Free Medical Clinic to have access to such information without the specific permission of the individual concerned.

CERTIFICATION: I certify that all entries on this application are true and I consent to references being contacted regarding this application.

_____ _____

Signature Date

FOR USE OF FREE MEDICAL CLINIC ONLY

Notified of orientation: 1._____ 2._____ 3._____

Attended orientation on:_____

Notified of training: 1._____ 2._____ 3._____

Attended training on:_____ Attached:

Began volunteering:_____ ☐ Health Record

Became inactive:_____ ☐ License on file