Volunteer Healthcare Clinic

"To help the most vulnerable have access to high quality health care and prevention education."

..... FOR OFFICE USE ONLY .....

Date Received: _____ Orientation Date: _____ Start Date: _____ Volunteer Type: _____

Volunteer Contact List: ☐ Background Ck: ☐ VHC Database: ☐ Email / Distribution Lists: ☐ Processed By: _____

***For Practitioners**: Date Reviewed: _____ Approved: Y / N _____ Medical Director: _____*

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.

Have you been a patient of the Volunteer Healthcare Clinic within the last three months? ☐ Yes ☐ No

PERSONAL INFORMATION

Full Name: _____ Preferred Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

E mail Address: _____

VOLUNTEER SERVICES

Please mark "X" in the area in which you are licensed and provide you license number:

1. ☐ Physician (MD, DO) - License #: _____ NPI #: _____
2. ☐ Family Nurse Practicioner (FNP) - License #: _____
3. ☐ Physician Assistant (PA) - License #: _____
4. ☐ Clinical Nurse Specialist - License #: _____
5. ☐ Nurse (RN, LVN) - License #: _____
6. ☐ Pharmacist (RPh) - License #: _____
7. ☐ Pharmacy Technician - License #: _____
8. ☐ Registered Dietitian - License #: _____

Please mark "X" in the area you have skills or interest:

9. ☐ Patient Registration / Office
10. ☐ Daytime Projects (clerical)
11. ☐ Phlebotomist – What is your experience with blood draws? _____
12. ☐ Fundraising
13. ☐ Spanish Interpreter

Please list your Occupation / Specialty: _____

Volunteer Healthcare Clinic

"To help the most vulnerable have access to high quality health care and prevention education."

LANGUAGE SKILLS

Do you speak fluent Spanish? ☐ Yes ☐ No ☐ Some ☐ Other Language:_____

SCHEDULE PREFERENCES
(For Doctors & Advance Practice Nurses Only)

Preferred clinic night: ☐ Monday ☐ Tuesday ☐ Thursday

☐ I am interested in a set schedule

Do you have privileges at any local hospital(s)?_____

VOLUNTEER EXPERIENCE / GOALS

Have you volunteered elsewhere? If so, where? _____

Why do you want to volunteer at the Volunteer Healthcare Clinic?

_____

Please list any other skills or experience (such as website design, marketing, writing, fundraising)

_____

How did you hear about us? _____

REFERENCES

Name & Phone :_____ 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 will include a background check. I understand that all files and records maintained by the Volunteer Healthcare Clinic (VHC) 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 VHC and acknowledge and understand that I must conform to the rules and regulations of the VHC to the best of my ability or my voluntary services may be terminated.

Signature:_____ **Date:** _____

4215 Medical Parkway ● Austin ● Texas ● 78756 ● Telephone (512) 459-6002 ● Fax (512) 459-3002 ● www.volclinic.org

Revised: 6/23/11