

Medservices Input:  Input:

**Volunteer Type**

- Administrative
- Dental Asst.
- Dentist
- Dietician
- Hygienist
- Nurse
- NP
- Pharmacist
- Pharmacy Assistant
- Pharmacy Technician
- Physician
- Other:** \_\_\_\_\_

**Skills/Interests**

- Computer (data entry)
- Patient Vital Signs
- Telephone (patient calls)
- Other:** \_\_\_\_\_
- Nutrition
- Organizational
- Patient Advocacy

## Rockbridge Area Free Clinic Volunteer Application

**Thank you for your interest in volunteering with the Rockbridge Area Free Clinic. Please complete this application so that we may best utilize your interest, skills, and abilities. If you have questions, please contact the Volunteer Coordinator at 464-8700, ext. 105.**

Printed First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Printed Last Name: \_\_\_\_\_

Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Birthday: \_\_\_\_\_ Professional License#: \_\_\_\_\_ Lic Expiration Date: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_

**Although there is no requirement, how often can you volunteer?**  
**Please check preferred days and times:**

Monthly  Weekly  Daily

	<b>9:00-12:30</b>	<b>1:30-4:00</b>	<b>5:00-7:30</b>
<b>Monday</b>	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	
<b>Tuesday</b>	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	
<b>Wednesday</b>	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Evening <input type="checkbox"/>
<b>Thursday</b>	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Evening <input type="checkbox"/>
<b>Friday</b>	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	
<b>Special Projects</b> (times vary)	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	
<b>On Call</b>	Morning <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Evening <input type="checkbox"/>

Are you a Student  YES  NO

If yes, check all that apply  Poverty Class  PreMed  I will need a letter of recommendation.

1. Have you ever worked or volunteered at the Rockbridge Area Free Clinic as an employee or a volunteer?  YES  NO

If yes, please explain: \_\_\_\_\_

2. Have you ever volunteered?  YES  NO

If yes, list where and describe duties: \_\_\_\_\_

3. Do you have any limitations on your ability to perform some volunteer duties?

YES  NO If yes, please explain: \_\_\_\_\_

4. What other languages do you speak besides English? \_\_\_\_\_

5. Would you be willing to interpret, if needed?  YES  NO

**Volunteer Application (continued)**

**Volunteer Pledge:** I promise to be dependable, conscientious, and faithful in appearing for the duty assigned. If I am unable to report to the clinic, I will contact the Volunteer Coordinator in advance so someone can cover my tasks. I will dress appropriately and act professionally at all times. I understand that I am representing the Clinic and my community as well as myself.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Confidentiality Statement:** I recognize and acknowledge: that the services the Rockbridge Area Free Clinic provides for its patients are CONFIDENTIAL and that to enable the Free Clinic to perform those services, its patients furnish health and financial information; that the good will of this Clinic depends, among other things, upon its keeping such information CONFIDENTIAL; and that because of my duties as a volunteer, I may come into the possession of this CONFIDENTIAL information. I agree to protect this CONFIDENTIAL information to the best of my ability and not to divulge it during my volunteer experience or after my service has ended.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

*My signature indicates that I understand my obligation to maintain the confidentiality of any information acquired through my association with the Rockbridge Area Free Clinic and that I agree to abide by the confidentiality policies of the Clinic.*

**Personal Reference:** Please list below the name and address of a personal reference and sign giving us authorization to contact the person by phone, email or mail for a reference.

Name/Title: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**I authorize the Rockbridge Area Free Clinic to contact the person listed above as a personal reference in connection with my volunteer position.**

**Volunteer Coordinator Pledge:**

**I promise to be conscientious in providing the training needed to perform tasks assigned you and in assisting you in your role as a Volunteer at the Rockbridge Area Free Clinic. If I am unable to train or assist you directly, another staff member or a knowledgeable volunteer will train you. You will be treated as the professional you are and kept informed of any Clinic changes that may affect your Volunteer Tasks.**

\_\_\_\_\_  
Signature of Volunteer Coordinator

\_\_\_\_\_  
Date