



Lafayette
Community
Health Care
+ Clinic +

VOLUNTEER APPLICATION

Name: _____ Social Security #: _____
(Print) Last First Middle

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Home Fax: _____ Birthdate: _____

Home e-mail Address: _____

Spouse's Name: _____ Birthdate: _____

Recruited to Volunteer By: _____

Demographic Information

Gender: Circle one Male Female
 Race/Ethnicity: Circle one African-American Asian Caucasian
 Hispanic/Latino Pacific Islander Native American Other

Employment Information

Name of Employer (or Retired from): _____

Occupation: _____

Employer's Address: _____
Street City State Zip

Employer's Phone: _____ Employer's Fax: _____

e-mail address at Work: _____

Name of Office Manager at Work: _____ His/Her Birthdate: _____

Spouse's Employer (or Retired from): _____

Spouse's Occupation: _____

Spouse's Employer's Address: _____
Street City State Zip

Spouse's Employer's Phone: _____

Does your employer have matching funds for volunteering Yes No

General Information

Do you have any friends or relatives volunteering here? Yes No

If yes Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Where did you learn about our volunteer opportunities? _____

Are you seeking to volunteer in order to satisfy court-ordered community service?

Yes No

If yes, list the reason: _____

Have you ever pled guilty or “no contest” to a crime or been convicted of a crime?

Yes No

If yes, explain. _____

As a licensed professional, has your license ever been revoked or suspended? Yes No

If yes, explain:

Driving Information

Do you have a current driver’s license? Yes No

State: _____ License #: _____ Expiration Date: _____

Has your driver’s license ever been suspended or revoked? Yes No

If yes, please explain circumstances: _____

Availability

This section will help determine the best days and times for your volunteer activity. Please indicate times you will be available to volunteer below on a particular day of the week.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Times Available							

How long will you be available to volunteer at the above times? _____

Number of times you are available to volunteer: _____
(i.e. every third Monday, first and third Thursdays, once per quarter, monthly, etc.)

Areas of Interest

Is there a particular type of volunteer work in which you are interested?

Check all that apply to you.

Licensed Health Care Professionals

- | | | |
|--|--|--|
| <input type="checkbox"/> Physician (MD) | <input type="checkbox"/> Dentist (DDS) | <input type="checkbox"/> Pharmacist (RPh) |
| <input type="checkbox"/> Nurse (NSE)Dental | <input type="checkbox"/> Hygienist (RDH) | <input type="checkbox"/> Nurse Practitioner (NP) |
| <input type="checkbox"/> Physical Therapist (PT) | <input type="checkbox"/> Dietitian (RD) | |
| <input type="checkbox"/> Other _____ | | |

Other Clinical Support

- | | |
|---|--|
| <input type="checkbox"/> Dental Assistant (DA) | <input type="checkbox"/> Pharmaceutical Access (PAP) |
| <input type="checkbox"/> Patient Eligibility Screening (ES) | <input type="checkbox"/> Patient Intake (IN) |
| <input type="checkbox"/> Patient Exiting (EX) | <input type="checkbox"/> Medical Records (MR) |

Administrative, Office & Other Support

- | | |
|--|---|
| <input type="checkbox"/> General Clerical (GC) | <input type="checkbox"/> Receptionist (REC) |
| <input type="checkbox"/> Bulk Mailings (MAI) | <input type="checkbox"/> Word Processing (WP) |
| <input type="checkbox"/> Newsletter Editor's Assistant (NWS) | <input type="checkbox"/> Fund Raising (FR) |
| <input type="checkbox"/> Building Maintenance/Repairs (R&M) | <input type="checkbox"/> Janitorial (JAN) |
| <input type="checkbox"/> Public Relations (PR) | <input type="checkbox"/> Care of Grounds (GC) |
| <input type="checkbox"/> Data Entry (DE) | <input type="checkbox"/> Volunteer Meal Donor (VMD) |
| <input type="checkbox"/> Kitchen Hostess (KH) | <input type="checkbox"/> Other _____ |

Other Volunteer Opportunities

- | | |
|---|--|
| <input type="checkbox"/> Marketing Work Group | <input type="checkbox"/> Finance Work Group |
| <input type="checkbox"/> Clinic Standards & Policy Work Group | <input type="checkbox"/> Professional/Volunteer Work Group |
| <input type="checkbox"/> Board of Directors | <input type="checkbox"/> Board of Advisors Member |
| <input type="checkbox"/> Facilities Work Group | <input type="checkbox"/> Legislative Liaison/Work Group |

Skills and Experiences

- | | |
|---|---|
| <input type="checkbox"/> Computer Literate | <input type="checkbox"/> Filing |
| <input type="checkbox"/> Phone Answering Skills | <input type="checkbox"/> Composition (letter/grant writing) |
| <input type="checkbox"/> Language(s) Spoken (besides English) | <input type="checkbox"/> Good Customer Service |

What sorts of hobbies, interests, and activities do you enjoy? _____

Personal References

Please list three individuals who know you well (other than relatives and previous employers):

Name	Occupation	Address	Telephone Number	Number of Years Known

Emergency Contact Information

In case of an accident or an emergency, whom should we contact?

Name: _____

Relationship: _____

Home Address: _____
Street City State Zip

Home Telephone: _____ Cell Phone: _____

Work Address: _____
Street City State Zip

Work Telephone: _____

Acknowledgements

Statement of Confidentiality

As a member of the Lafayette Community Health Care Clinic, information on patients and their families will be shared with you as a part of patient medical and dental treatment. As a professional, this shared information is confidential and must not be discussed with anyone **NOT** affiliated with the Clinic.

This confidentiality extends to all information received during your interactions with patients. Your relationship with patients and families should never become a topic of social conversation, reports, or articles. While your work as a volunteer is a very important part of your life, you are encouraged to share with others the work and insights you have gained at the Lafayette Community Health Care Clinic, as long as patients' identity, personal life, and medical condition is not discussed.

I understand and I am willing to abide by the Statement of Confidentiality.

Signature of Volunteer

Date

Consent to Background Check:

I, _____, hereby authorize the Lafayette Community Health Care Clinic and its employees and agents to conduct a criminal background check and to investigate any and all matters related to my personal background. I consent to the Lafayette Community Health Care Clinic and its employees and agents use of any source and reference in seeking, obtaining and utilizing information related to my personal background including any and all criminal information, criminal records and/ or records maintained by previous employers and any local, state or federal agency.

I hereby authorize _____ to release any and all information related to my criminal background and/ or personal history and specifically release _____ from any and all claims related to the communication and release of such information to the Lafayette Community Health Care Clinic and it employees and agents.

The criminal background check and personal history and reference search is in no way limited and I expressly authorize and consent to the use of any method and/ or access of any record by the Lafayette Community Health Care Clinic and its employees and agents.

Signature of Applicant

Date

Signature of Witness

Date

I certify that all of the information that I provide on this application and in any interviews will be true and accurate. I understand that if I am approved to be a volunteer and any such information is later found to be false or misleading in any respect, I may be immediately dismissed.
