



Volunteers in Medicine

OF MONROE COUNTY

vimmonroecounty.org

Volunteer Application Form

Today's Date: _____ [For office use only PIN: _____]

Last Name: _____ First Name: _____ M.I.: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Business Phone: _____ Cell Phone: _____

Email: _____

Date of Birth (optional): (month/day/year) _____

Are you employed? (circle one) NO or YES

Employer: _____

Have you ever volunteered anywhere else? (circle one) NO or YES

If yes, where and for how long?

Level of Education/Degrees Held: _____

Licenses/Certifications: _____

Do you speak any foreign languages? (circle one) NO or YES

If yes, what language(s)? _____

Skill Level: Fluent: _____ Conversational: _____ Language: _____

Skill Level: Fluent: _____ Conversational: _____ Language: _____

List special skills/experience you would bring to this organization: _____

Have you ever been convicted of a crime (felony or misdemeanor)? (circle one) NO or YES

If yes, please explain in detail: _____

Why would you like to volunteer at Volunteers in Medicine of Monroe County?

Are you mandated to perform volunteer hours? Is this for class credits? (circle one) NO or YES

How many hours? _____ By whom: _____

What are your hobbies and interests? _____

How did you hear of this organization? _____

Clinic Hours/Shifts: M, T, W, Th, F; 8am to noon; 1pm to 5 pm; M & Th; 5pm to 8 pm.

What shifts are you available to volunteer? Please list the periods that you are available.

Mon: _____

Tues: _____

Wed: _____

Thurs: _____

Fri: _____

Total Hours you would like to volunteer: _____ (circle one) WEEKLY or BI-WEEKLY

Are there are any exceptions or conflicts with the above hours? (circle one) NO or YES

If yes, please list them:

Please let us know your **top 3 choices** for a volunteer position with the clinic (#1 being your first choice):

- _____ Greeters
- _____ Receptionists
- _____ Eligibility Interviewers
- _____ Appointment Schedulers
- _____ Data Entry Volunteers
- _____ Interpreters (Spanish)
- _____ Medical Record Volunteers
- _____ Clerical Assistants
- _____ Medication Room Volunteers
- _____ Dental Assistants
- _____ Nursing Receptionists
- _____ Community Outreach Volunteers
- _____ Event Planning Volunteers
- _____ Other

Please provide two references (please do not include relatives):

1. Name: _____ Phone Number: _____
City _____ State: _____ How long have you known this person? _____
What would this person say about you?

2. Name: _____ Phone Number: _____
City _____ State: _____ How long have you known this person? _____
What would this person say about you?

I certify that all the statements herein on this volunteer information sheet are true and correct and have been given voluntarily. I understand that this information may be shared with any legal and proper interest, and I release the agency from any liability whatsoever for supplying such information. I understand I will not be paid for my services in my volunteer capacity. I agree to abide by Volunteer in Medicine of Monroe County's policies and procedures.

I also allow Volunteers in Medicine of Monroe County to use my picture(s) and/or comments for newsletters, public relations mailings and any other Volunteers in Medicine related, legitimate purpose.

Applicant Signature _____

Date: _____

Confidentiality Statement

Due to the nature of this organization, Volunteers in Medicine of Monroe County require that all volunteers sign a confidentiality agreement. By signing below, you agree to adhere to this policy:

I shall hold in confidence all pertinent information. I will not violate the confidential relationship between Volunteers in Medicine of Monroe County and its patients, donors, staff, volunteers, and any other party. I will not remove any written record from Volunteers in Medicine of Monroe County without expressed written permission and I will not discuss patient or any other sensitive information with anyone, except in the performance of my duties with Volunteers in Medicine of Monroe County.

I will accept full responsibility for my actions in maintaining the confidential and privileged nature of all records and information. I also understand that disclosing information will result in immediate action up to and including dismissal from my volunteer position.

Signature: _____

Date: _____

Witness: _____

Date: _____

Emergency Information

Please Print Clearly

Date: _____

Last Name: _____

First Name: _____ M.I.: _____

In the event of an emergency, please notify this person:

Name: _____

Relationship: _____

Home Phone Number: _____

Business Phone: _____

Cell Phone Number: _____

Alternate Contact for emergencies:

Name: _____

Relationship: _____

Home Phone Number: _____

Business Phone: _____

Cell Phone Number: _____

Do you have any medical conditions or limitations that might affect your ability to perform the volunteer duties, or that Volunteers in Medicine of Monroe County should be aware of?

If yes, please explain: _____

Signature: _____

Date: _____