VOLUNTEER MEDICAL SCRIBE APPLICATION

VOLUNTEER INFORMATION:

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ PREFERRED NAME _____

BIRTHDATE _____ PHONE NUMBER _____ EMAIL ADDRESS _____

STREET ADDRESS _____ CITY, STATE _____ ZIP CODE _____

DO YOU SPEAK ANY LANGUAGES OTHER THAN ENGLISH? _____

HAVE YOU VOLUNTEERED AT THE DVC BEFORE? ☐ YES ☐ NO
IF YES, WHEN? _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? ☐ YES ☐ NO
IF SELECTED, ARE YOU WILLING TO SUBMIT TO A BACKGROUND CHECK? ☐ YES ☐ NO

VOLUNTEER AVAILABILITY:
PLEASE MARK ALL THAT APPLY FOR YOUR VOLUNTEER AVAILABILITY.

	9:00AM – 12:00PM	12:00PM – 1:00PM	1:00PM – 4:00PM
MONDAY	☐	CLINIC CLOSED	☐
TUESDAY	☐	CLINIC CLOSED	☐
WEDNESDAY	☐	CLINIC CLOSED	☐
THURSDAY	☐	CLINIC CLOSED	☐
FRIDAY	☐	CLINIC CLOSED	CLINIC CLOSED

FREQUENCY:
☐ WEEKLY
☐ TWICE A WEEK

AVAILABLE START DATE: _____

MEDICAL EXPERIENCE:
☐ MEDICAL ASSISTANT ☐ PRE-MEDICAL STUDENT ☐ MEDICAL SCRIBE

☐ TYPE 60 WORDS PER MINUTE (*REQUIRED*)

PLEASE LIST ANY ADDITIONAL MEDICAL CREDENTIALS AND/OR EXPERIENCE:

_____

_____

APPLICANT SIGNATURE CERTIFIES THAT ALL ANSWERS GIVIN HERIN ARE ACCURATE AND COMPLETE.

_____ _____

APPLICANT SIGNATURE DATE