DOCTORS' VOLUNTEER CLINIC

VOLUNTEER PATIENT TECH 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: **AVAILABLE START DATE: _____**
[ ] WEEKLY
[ ] TWICE A WEEK

MEDICAL EXPERIENCE:
PRIOR EXPERIENCE IS NOT REQUIRED BEFORE VOLUNTEERING AT THE DVC.
[ ] MEDICAL ASSISTANT   [ ] PRE-MEDICAL STUDENT   [ ] PHLEBOTOMY   [ ] MEDICAL SCRIBE

PLEASE LIST ANY ADDITIONAL MEDICAL CREDENTIALS AND/OR EXPERIENCE:
_____
_____

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

_____   _____
APPLICANT SIGNATURE   DATE