VOLUNTEER PROVIDER 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
☐ MONTHLY

AVAILABLE START DATE: _____

MEDICAL PRACTICE:

CREDENTIALS: _____

AREA OF SPECIALTY: _____

I AM A CURRENT PRACTICING PHYSICIAN [ ] YES [ ] NO
I AM A RETIRED PHYSICIAN WHO WOULD LIKE TO VOLUNTEER [ ] YES [ ] NO

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

APPLICANT SIGNATURE	DATE