



Volunteer Application

Please Print Clearly!

When complete, return to the Volunteer Coordinator

Name: _____ Date: _____

Home Phone: _____ Cell: _____ Business: _____

E-mail: _____

Preferred method of contact: Home Business E-mail Any

CURRENT or MAILING ADDRESS

Address _____

City / State _____ Zip _____

PERMANENT ADDRESS (if different)

Address _____

City / State _____ Zip _____

EMPLOYMENT INFORMATION

I am: Employed Un-employed Retired Student

Employer / School _____ Occupation _____

Employer Address _____ Department / Suite Number _____ City /

State _____ Zip _____ Business Phone _____

Professional Employment / Practice History

Date Started

Date Ended

Position Responsibilities

EDUCATION

(Check all that apply – please note degrees in progress)

H.S. diploma: School _____ City / St. _____ Yr _____
 Undergrad degree: School _____ City / St. _____ Yr _____ Major _____ Grad
 degree: School _____ City / St. _____ Yr _____ Major _____

Educational Training / Licenses or Certifications (list all applicable degrees & credentials):

I am age 18 or older **Birth**day: _____ **Gender:** _____ Any
languages other than English (including sign language)? _____

**** PLEASE ATTACH A PHOTOCOPY OF YOUR CURRENT PROFESSIONAL LICENSES. ****

SERVICE OPPORTUNITIES

What do you want to do? Order your interests by NUMBER (first choice = 1, second choice = 2, ect.). For job descriptions, requirements, & time commitments, call the Volunteer Coordinator.

MEDICAL CLINIC

Patient Registration (History Taker) Lab Tech / Phlebotomist
 Pharmacy Technician
 Registered Pharmacist

Well Physical Examiner (med students) Practitioner / Physician
 Resident
 Certified Nursing Assistant

Medical Clerical Support & Projects RN / LPN
 Nutritionist / Dietician / Diet Tech Nurse Practitioner

Dental Student Student Intern Therapist Psychiatrist Intake Worker

ADMINISTRATIVE

___ Clerical / Typist
___ Computer Work / Data Entry ___ Chart Filing
___ Other

SPECIAL PROJECTS

___ Remote Area Medical ___ ETSU Health Fair

COMMUNITY EDUCATION

___ Health Education Outreach

Have you volunteered at the Health Wagon before? _____ How
did you hear about our needs at the Health Wagon? _____ Is there
anything else you would like us to know about you (i.e., career goals, special needs,
etc.)? _____

How often would you like to volunteer?

___ one time / specific project ___ 1-2 times per month ___ 1x / week ___ 2x / week ___ more than 2x / week

How long of a commitment can you make as a volunteer? ___ 3 months ___ 6 months ___ 9 months ___ more than 1 year

PLEASE LIST THE TIMES YOU ARE AVAILABLE TO VOLUNTEER BELOW

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Morning's _____

Afternoon's _____

TWO REFERENCES MUST BE PROVIDED BEFORE YOU BEGIN YOUR SERVICE

*Both Volunteer Professional Reference Check Forms must be attached with your Application.

App Rec: Refs Verified: 1 2 3 Date: Start Date/ Active

FOR OFFICE USE ONLY

:

Thank you for agreeing to be a reference for our volunteer. Please complete this entire form. Our volunteers must have at least two written references on file before they can provide service with our organization. Your reference check form must be returned to the address above in a sealed (unopened) envelope with your signature written across the seal. Your cooperation and quick response (within 1 week upon receipt of this form) is greatly appreciated.

Potential Volunteer's Name: _____
Reference Name: _____ Title: _____
Organization: _____
Address: _____ City: _____
_____ State: _____ Zip: _____ Phone: _____
_____ Fax: _____ E-mail: _____

Questions, please rate Unsatisfactory(U) Satisfactory(S) Excellent(E)

How would you rank this individual's quality of work? _____ How
would you rank this individual's dependability? _____ What is/was
this individual like to interact with as a
co-worker, employee, associate or student? _____ How is/was this
individual's involvement with clients/

patients/ customers/ others? _____ How would you rank this
individual's leadership
capabilities? _____

How long have you known this individual? _____ What is
your relationship to this individual? _____ In order to
ensure the highest possible quality of care for patients, please briefly describe any areas of
concern that we should know about regarding this individual. _____
_____ Would
you recommend this individual for a volunteer position with our organization?

Additional comments can be written on the back.

Reference's Signature: _____ Date: _____