VOLUNTEER APPLICATION

McMinnville Free Clinic

www.mcminnvillefreeclinic.org

First Name: _____ Middle Name: _____ Last Name: _____

Maiden/Other Names Previously Used: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Email: _____ School Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Position: _____

Emergency Contact Name: _____ Emergency Phone: _____

Licenses: _____ Special Training: _____

Are you Bi-lingual? ☐ No ☐ Yes, what languages? _____

What volunteer opportunities are you interested in? (click on the box for all that apply)

- ☐ Nurse* (procedures, education, etc.)
- ☐ Reception (check-in)
- ☐ Facilities (set up/take down of Clinic)
- ☐ Medical Records (maintain patient charts)
- ☐ Greeter (welcome & direct patients)
- ☐ Prayer Team (spiritual support)
- ☐ Interpreter
- ☐ Provider* (MD, DO, NP, PA, PT, DC, etc.)
- ☐ Provider Support (assist Providers, help with Facilities)
- ☐ Triage (vital & labs)
- ☐ Community Resources (help connect patients with resources)
- ☐ Office Support (filing, phones, faxes, supplies)
- ☐ Volunteer Coordinator (process applications, volunteer support)
- ☐ Marketing/Social Media/Fundraising/Grant Writing/Technology

* Nurse and Provider requires a License

How often would you like to volunteer?

☐ Twice per month ☐ Monthly ☐ Quarterly ☐ As needed ☐ Other: specify _____

Applicant Agreement

I understand and agree that the information supplied, was submitted by myself, and all information is true and correct, to the best of my knowledge. I agree to abide by all policies and procedures of the McMinnville Free Clinic. McMinnville Free Clinic has my authorization to thoroughly investigate my criminal history, medical and professional licensing, employment history, education, and references as needed, as part of the screening process. I release from liability all persons, companies, and corporations giving or receiving information in this investigation. If I am a licensed medical provider, I am aware that I will also need to be credentialed in order to qualify for FTCA (Federal Tort Claims Act) malpractice coverage. Acceptance as a volunteer is contingent on a review of my background and that a letter of reference may be requested.

_____ _____

Volunteer Signature **Date**

E-mail applications to: volunteercoord@mcminnvillefreeclinic.org

Mail applications to: McMinnville Free Clinic

c/o McMinnville Covenant Church

2155 NW Second Street, McMinnville, OR 97128

Revised Feb 2018