Volunteer Application

Mail applications to: McMinnville Free Clinic 125 SE Cowls Street, McMinnville, OR 97128
E-mail applications to: volunteercoord@mcminnvillefreeclinic.org

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

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

Address: _____ City/State/Zip: _____

Email: _____ Cell Phone: _____

Emergency Contact Name: _____ Emergency Phone: _____

Employer: _____ Position: _____

Address: _____ Phone: _____

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

What volunteer opportunities are you interested in?

- ☐ **Nurse (procedures, education, etc.) ***
- ☐ **Reception (check-in)**
- ☐ **Facilities (clinic set up/take down)**
- ☐ **Medical Records (maintain charts)**
- ☐ **Prayer Team or Greeter (front door)**
- ☐ **Interpreter**
- ☐ **Provider (MD, DO, NP, PA, PT, DC, etc.)***
- ☐ **Provider Support (escort patients, assist with Facilities)**
- ☐ **Triage (vitals & labs)***
- ☐ **Community Resources (find resources / fill out applications)**
- ☐ **Office Admin/Volunteer Care (filing, phones, faxes, supplies)****
- ☐ **Marketing/Fundraising/Grant Writing/Technology ****

Volunteer hours are available from 8:00 am – 2:00 pm every 1st and 3rd Saturday of the month.

*** These positions require a License and/or certification.** **** The hours for these positions vary during the week.**

Licenses and Certificates: *Please indicate the license and/or certificate type and number.*

Type and number: _____

Professional School: *If you are a Provider or Nurse, please skip this section and attach your signed OPCA application.*

Name: _____ Grad Date: _____

Address : _____

Other Special Skills and/or Training: _____

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

_____ _____

Volunteer Signature **Date**

Visit our website at: mcminnvillefreeclinic.org