

PROFESSIONAL VOLUNTEER APPLICATION

PERSONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE INT	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP
			<input type="checkbox"/> RPh <input type="checkbox"/> DDS
			<input type="checkbox"/> OTHER _____
SPECIALTY	WOULD YOU PREFER TO BE CONTACTED BY:		
	<input type="checkbox"/> WORK PHONE	<input type="checkbox"/> HOME PHONE	<input type="checkbox"/> CELL PHONE <input type="checkbox"/> EMAIL
ADDRESS	STREET	CITY	STATE ZIP DATE OF BIRTH
HOME PHONE	WORK PHONE	CELL PHONE	
()	()	()	
PAGER	E-MAIL ADDRESS		
()			
ARE YOU AWARE OF ANY MEDICAL, PHYSICAL OR MENTAL HANDICAP THAT WOULD AFFECT YOUR ABILITY TO PERFORM PROFESSIONAL DUTIES?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:			
ARE YOU PRESENTLY EMPLOYED BY OR CONNECTED WITH MIDMICHIGAN HEALTH OR OTHER MEDICAL FACILITY?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:			
CURRENT WORK SITE (PRACTICE/PHARMACY NAME)			
DO YOU HAVE TRAINING/EXPERIENCE IN ANY SPECIAL AREA?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE DESCRIBE:			
DO YOU SPEAK A FOREIGN LANGUAGE?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST:			
HAVE YOU EVER BEEN DENIED HOSPITAL PRIVILEGES OR BEEN ASKED TO GIVE UP PRIVILEGES?			
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:			

PROFESSIONAL REFERENCES

NAME					PHONE NUMBER
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ADDRESS	STREET	CITY	STATE	ZIP
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NAME					PHONE NUMBER
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ADDRESS	STREET	CITY	STATE	ZIP
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EMERGENCY CONTACT

NAME	RELATIONSHIP			PHONE NUMBER
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ADDRESS	STREET	CITY	STATE	ZIP
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ASSIGNMENT PREFERENCES

<u>CLINIC DAY - SATURDAYS</u>	<u>ALTERNATE SERVICE AREAS (Approximate time)</u>
<input type="checkbox"/> NURSING 8:45AM - CLOSE	<input type="checkbox"/> CHART REVIEW Monday's
<input type="checkbox"/> CHECK-OUT 8:45AM - CLOSE	<input type="checkbox"/> OFFICE WORK Variable Times
<input type="checkbox"/> INTAKE (INTERVIEWS) 8:45AM - 2:00PM	<input type="checkbox"/> FUND RAISING Variable Times
<input type="checkbox"/> FRONT OFFICE 8:45AM - CLOSE	<input type="checkbox"/> EVENTS Variable Times
<input type="checkbox"/> GREETER 8:45AM - 2:00PM	<input type="checkbox"/> OTHER AREAS OF INTEREST (LIST BELOW)
<input type="checkbox"/> PHYSICIAN 9:30AM - CLOSE	_____
(Approximate Times)	_____

SIGNATURE GIVES PERMISSION TO CREDENTIAL

SIGNATURE	DATE
X	

OFFICE USE ONLY

<input type="checkbox"/> TB TEST	<input type="checkbox"/> HIPAA TRAINING	<input type="checkbox"/> BLOODBORNE PATHOGENS
<input type="checkbox"/> LICENSE _____	<input type="checkbox"/> DEA _____	<input type="checkbox"/> MALPRACTICE RIDER

GCFC SIGNATURE	DATE
X	