

## VOLUNTEER APPLICATION

### PERSONAL INFORMATION

LAST NAME		FIRST NAME		MIDDLE INT		<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> MA <input type="checkbox"/> CNA <input type="checkbox"/> OTHER _____	
DO YOU PREFER A NICKNAME		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					
(   )							
HAVE YOU EVER BEEN A VOLUNTEER?							
<input type="checkbox"/> YES <input type="checkbox"/> NO		WHEN? (APPROX)		WHERE?			
ARE YOU AWARE OF ANY MEDICAL, PHYSICAL OR MENTAL HANDICAP THAT WOULD AFFECT YOUR ABILITY TO PERFORM VOLUNTEER 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 EMPLOYER		PHONE NUMBER		MAY WE CONTACT YOUR WORK		DATES OF EMPLOYMENT	
				<input type="checkbox"/> YES <input type="checkbox"/> NO			
PREVIOUS EMPLOYER		PHONE NUMBER		MAY WE CONTACT YOUR WORK		DATES OF EMPLOYMENT	
				<input type="checkbox"/> YES <input type="checkbox"/> NO			
COMMUNITY AFFILIATIONS							
EDUCATION							
<input type="checkbox"/> HIGH SCHOOL		<input type="checkbox"/> COLLEGE		<input type="checkbox"/> OTHER:			
ARE YOU PRESENTLY A STUDENT?							
<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHERE:					
DO YOU HAVE TRAINING/EXPERIENCE IN ANY SPECIAL AREA?							
<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE.					
PLEASE LIST ANY SPECIAL SKILLS OR ABILITIES YOU POSSESS							
<input type="checkbox"/> COMPUTER		<input type="checkbox"/> FUNDRAISING		<input type="checkbox"/> FILING		<input type="checkbox"/> OTHER:	
DO YOU SPEAK A FOREIGN LANGUAGE?							
<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST					

**REFERENCES (Other Than Relatives)**

<b>NAME</b>		<b>PHONE NUMBER</b>		
<b>ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>

<b>NAME</b>		<b>PHONE NUMBER</b>		
<b>ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>

**EMERGENCY CONTACT**

<b>NAME</b>		<b>RELATIONSHIP</b>	<b>PHONE NUMBER</b>	
<b>ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>

**ASSIGNMENT PREFERENCES**

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

<b>SIGNATURE</b>	<b>DATE</b>
<b>X</b>	

**OFFICE USE ONLY**

<input type="checkbox"/> <b>TB TEST</b>	<input type="checkbox"/> <b>HIPAA TRAINING</b>	<input type="checkbox"/> <b>BLOODBORNE PATHOGENS</b>	<input type="checkbox"/> <b>LICENSE</b>
<b>GCFC SIGNATURE</b>		<b>DATE</b>	
<b>X</b>			