

His Hands Free Medical Clinic

VOLUNTEER APPLICATION

INSTRUCTIONS: Section I should be completed all volunteers. Section II should be completed by medical and licensed volunteers. If you have questions, please contact us at 862-2636 or director@hishandsclinic.org

SECTION I.

Full Name _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____ Work Phone _____

Email _____ Cell Phone _____

Preferred method of communication: Email Home phone Work phone Cell Phone

How did you hear about His Hands?

POSITION OF INTEREST

Medical Positions

- Physician
- Physician Assistant
- Nurse Practitioner
- RN/LPN
- Pharmacist
- Pharmacy Assistant
- Chiropractor
- Physical Therapy or Massage Therapy

Non-Medical Positions

- Social Worker (requires a valid license)
- Receptionist/Clerical
- Prayer Support
- Data Entry
- Cleaning
- Other _____

EDUCATIONAL HISTORY AFTER HIGHSCHOOL

School (include Internships and Residencies)	City and State	Year Graduated	Certificate/Degree
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EMPLOYMENT HISTORY

Employed, at: _____ Position: _____

Retired, since _____ (date)

Previous Employment or Volunteer Experience that might be relevant to your volunteer position:

Please list times you are available to volunteer. Circle your first preference(s) and underline your second preference(s).

- Week day mornings (circle which days) Mon Tues Wed Thurs Fri
- Week day afternoons (circle which days) Mon Tues Wed Thurs Fri
- Evenings (circle which days) Mon Tues Wed Thurs Fri

EMERGENCY CONTACT: In case you were in an emergency while volunteering, who should we contact?

Name: _____ **Relationship to you:** _____
Number: _____ **Additional Number:** _____

REFERENCES: Please list below two individuals who are not related to you who can provide a reference on your ability to serve as a volunteer at the Clinic.

1. Name: _____ **Address:** _____
Relationship to you: _____ **Phone:** _____

2. Name: _____ **Address:** _____
Relationship to you: _____ **Phone:** _____

I hereby agree and consent to the Clinic Director or Medical Director contacting the references listed above about my ability to serve as a Clinic volunteer.

Signature

Date

SECTION II. ADDITIONAL INFORMATION NEEDED FOR MEDICAL OR LICENSED VOLUNTEERS

Iowa License Number: _____ **Expiration Date** _____

If not licensed, identify any certification or registration: _____
Expiration Date: _____

If licensed, has your license to practice, in any jurisdiction ever been suspended or not renewed?

- No**
- Yes, please explain in full detail on the back of this form.**

*****PLEASE ATTACH A COPY OF YOUR CURRENT LICENSE , CERTIFICATION OR REGISTRATION*****

MALPRACTICE INSURANCE

Do you have malpractice insurance that will cover your volunteer activities at His Hands?

- Yes, please provide a copy of the declaration page of your policy**
- No (We will provide you information about the Volunteer Healthcare Provider Program.)**

Return the application to:
His Hands Free Medical Clinic
PO Box 339
Cedar Rapids, IA 52406
OR
director@hishandsclinic.org