



1043 Third Avenue SE
 PO Box 339
 Cedar Rapids, IA 52406
 319-862-2636

Office Use Only:	
_____	Attended Volunteer Orientation
_____	Entered into GW
_____	Added to schedule

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 info@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
- Follow-up Nurse

Non-Medical Positions

- Social Worker
- Receptionist
- Prayer Support
- Administrative Assistant
- Appointment Scheduler
- Hospitality Coordinator
- Marketing/Fundraising Assistant
- Newsletter Crew

EDUCATIONAL HISTORY AFTER HIGHSCHOOL (include Internships and Residencies)

School	City and State	Year Graduated	Certificate/Degree
--------	----------------	----------------	--------------------

EMPLOYMENT HISTORY

Currently 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

How often would you like to volunteer? Monthly Twice a month Weekly

Short-term (how long) _____

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

Name: Relationship to you:

Number: Additional Number:

REFERENCES: Please (preferably) have an individual who is NOT related to you fill out the Reference Form at the end of this application. *Otherwise*, 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 this application to:			
His Hands Free Medical Clinic PO Box 339 Cedar Rapids, IA 52406	OR	info@hishandsclinic.org	OR fax it to: 319-862-1107



1043 Third Avenue SE
 PO Box 339
 Cedar Rapids, IA 52406
 319-862-2636

Volunteer Recommendation Form

Name of Applicant _____

Our Mission: At His Hands Free Medical Clinic, we strive to bring glory to God by meeting the physical, emotional, and spiritual needs of those without adequate resources. We acknowledge the sovereignty of Jesus Christ as Lord and seek to grow in Christlikeness as we serve our patients, recognizing the God-given dignity of each human life.

1. What is your association with the volunteer, and how well do you know him or her?

2. Listed below are some of the desirable qualities of a volunteer. Please rate the applicant on these items:

Quality	Excellent	Above Average	Average	Below Average	Do Not Know
Kind & Caring					
Team-Player					
Reliable					
Competent or teachable					
Trustworthy					
Positive Attitude					

3. Does this person work well with others?

4. Is this person sensitive to the needs of others?

5. What are the top 3 qualities of the volunteer?

Name of Evaluator _____ Telephone _____

Signature _____ Date _____

<u>Return this form to the applicant, or you can:</u>		
mail it to: His Hands Free Medical Clinic PO Box 339 Cedar Rapids, IA 52406	OR	fax it to: 319-862-1107