



# CHESAPEAKE CARE FREE CLINIC VOLUNTEER APPLICATION

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
(last) (first) (middle)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: ( ) - - WORK PHONE: ( ) - -

CELLULAR: ( ) - - PAGER: ( ) - -

E-MAIL: \_\_\_\_\_ DOB: mm/dd \_\_\_\_\_

EASIEST WAY TO CONTACT YOU: \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

1. Are you volunteering to complete a requirement? Yes / No  
If yes, which organization referred you? \_\_\_\_\_  
Organization Contact Person & Phone # \_\_\_\_\_  
If yes, how many hours do you require? \_\_\_\_\_  
If yes, what is your required date of completion? \_\_\_\_\_
2. Do you have any health problems that may affect your volunteer assignment?  
Yes / No If Yes Please explain \_\_\_\_\_
3. How did you learn about the Chesapeake Care Free Clinic? \_\_\_\_\_  
\_\_\_\_\_

## FOR OFFICE USE ONLY

Orientation Scheduled \_\_\_\_\_ Completed \_\_\_\_\_

Folder \_\_\_\_\_ Name Tag \_\_\_\_\_

Database updated \_\_\_\_\_

4. References

Name \_\_\_\_\_ phone# \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ phone# \_\_\_\_\_ Relationship \_\_\_\_\_

5. Affiliations

Civic Organizations \_\_\_\_\_ Professional Associations \_\_\_\_\_

Church \_\_\_\_\_ Board Member \_\_\_\_\_

6. How often would you be able to volunteer? \_\_\_\_\_

7. Your Preferred Volunteer Times: (Circle)

Monday AM - Monday Afternoon - Monday PM

Tuesday AM - Tuesday Afternoon - Tuesday PM

Wednesday AM - Wednesday Afternoon - Wednesday PM

Thursday AM - Thursday Afternoon - Thursday PM

Friday AM - Saturday AM

Other: \_\_\_\_\_

8. To respect the dignity of our patients, all medical information is CONFIDENTIAL and will not be discussed outside of the clinic. Any volunteer who does not respect this policy will not continue to volunteer at Chesapeake Care Free Clinic.

I understand the above \_\_\_\_\_ Date \_\_\_\_\_