Chesapeake Care, Inc.
Volunteer Application

Date: _____

First Name	Middle Name	Last Name	
Address:	City:	State:	Zip:
Cell:	Home:	DOB: MM DD	
Place of Employment:		Work No.	
Email:	Email:		
1) How did you learn about the Chesapeake Care Clinic?			
2) Are you volunteering to complete a requirement? ☐ Yes ☐ No			
If yes, which organization:	Contact person:	Phone number:	
Hours required	Required date of completion:		
3) Emergency Name:	**Emergency Phone number:**		
4) Your preferred volunteer times: (please circle below) or other:		How often would you be available?	

AM	AFTERNOON	PM
MO – TU – WE – TH – FR – SA	MO – TU – WE – TH – FR – SA	MO – TU – WE – TH – FR - SA

Licensed Volunteer

1) Are you active military? ☐ Yes ☐ No	2) Do you file a Virginia State Tax return? ☐ Yes ☐ No

3) Professional License:
____DDS ____DO ____LPN ____MD ____NP ____PA ____RDH ____RN ____RPH

4) Professional

License #: Initial License Date: Expiration Date: State License:

DEA# NPI#

If you have a professional license, you are protected from liability if you are practicing within the scope of your license without compensation at a free clinic. You can only be sued for willful negligence. In order to establish this protection, we must have a copy of your current license on file. Be advised that Universal Precautions must be followed for all patient contact.

I understand the above_____ Date_____

FOR OFFICE USE ONLY

Orientation Scheduled:	**Orientation Completed:**	**Contract/Confidentiality signed:**
Name Tag:	**Start Date:**	**Provider Number:**
Position:	**Note:**	

Revised June 2016