VOLUNTEER APPLICATION

Thank you for your interest in volunteering with Elica Health Centers. Your completed application will assist us in identifying potential volunteer opportunities that are best suited to your interests, experience, and learning objectives. Please attach a resume, if available.

PERSONAL INFORMATION

NAME	DATE
ADDRESS, CITY, STATE. ZIP	E-MAIL ADDRESS
HOME PHONE	MOBILE PHONE

CHECK ONE (OR MORE) OF THE FOLLOWING:
☐ EMPLOYED ☐ UN-EMPLOYED ☐ RETIRED ☐ STUDENT

AREA(S) OF INTEREST

☐ CLERICAL ☐ MOBILE MEDICINE AND OUTREACH ☐ SPECIAL EVENTS
☐ VOLUNTEER PROVIDER, MID-LEVEL PRACTITIONER, OR NURSE
☐ OTHER ____

ARE YOU REQUIRED TO COMPLETE CLINICAL HOURS TO FULFILL AN EDUCATIONAL PROGRAM? ☐ YES ☐ NO

If yes, list name of program____ Required hours to complete ____________________

Name of Institution ____

EDUCATION: ACADEMIC AND/OR VOCATIONAL

SCHOOL NAME	FIELD OF STUDY/DEGREE	GRADUATION YEAR	ENROLLMENT STATUS
			☐ ENROLLED ☐ GRADUATED
			☐ ENROLLED ☐ GRADUATED
			☐ ENROLLED ☐ GRADUATED

LANGUAGES SPOKEN

LANGUAGE	FLUENT? (Y/N)	VERBAL SKILLS (Basic, Intermediate, Advanced)	WRITTEN SKILLS (Basic, Intermediate, Advanced)

SKILLS (List computer skills, equipment skills, and/or other skills or aptitudes which may apply to this position)

Elica Health Centers
Healing with Heart

PROFESSIONAL LICENSE(S) AND CERTIFICATIONS			
NAME OF LICENSE OR CERTIFICATION	ISSUED BY	EXPIRATION DATE	STATE ISSUED

VOLUNTEER/WORK EXPERIENCE			
ORGANIZATION/EMPLOYER	DATE STARTED	DATE ENDED	POSITION HELD
DUTIES HELD:			
ORGANIZATION/EMPLOYER	DATE STARTED	DATE ENDED	POSITION HELD
DUTIES HELD:			

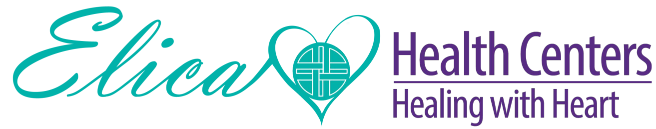
MY AVAILABILITY					
MONDAY	Morning	Afternoon	Evening	from	to
TUESDAY	Morning	Afternoon	Evening	from	to
WEDNESDAY	Morning	Afternoon	Evening	from	to
THURSDAY	Morning	Afternoon	Evening	from	to
FRIDAY	Morning	Afternoon	Evening	from	to

Do you know someone who is presently employed at Elica Health Centers? ☐ YES ☐ NO

If yes, please list their name(s) below:

Why do you want to volunteer and what do you hope to gain from serving at Elica Health Centers?

Is there anything else you would like us to know about you (i.e., career goals, special needs, etc.)?



I hereby authorize Elica Health Centers (EHC) to verify the accuracy of information contained in this volunteer application for all previous employers and educational institutions. I give EHC the authorization to check the status of my professional license as well as other authorities and agencies who may have pertinent information regarding any professional license or certificate I might use if offered employment with EHC.

I understand and agree that in the performance of my duties as a volunteer with EHC I must abide by all policies and procedures, including to hold as strictly confidential all medical information that I may obtain directly or indirectly concerning patients. I understand that failure to comply with these requirements may result in my dismissal as a volunteer.

Elica Health Centers reserves the right to decline volunteer assistance, when necessary. Completed volunteer applications and written qualifications do not guarantee an individuals' placement within the organization's volunteer program. Selection and appropriateness for all volunteer positions will be at the discretion of the department directors.

By signing below, I certify that the information I have provided in this application is accurate and true to the best of my knowledge and that no assertions have been falsified.

Volunteer Signature ___________________________________ Date: ___________________

Printed Name ____