TRINITY COMMUNITY CARE

VOLUNTEER APPLICATION

Last Name: _____ **First Name:** _____ **Date of Birth:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Preferred Contact: ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Text

Driver's License #: _____

Maiden/Former Name(s) Used: _____

Emergency Contact: _____

Phone: _____ **Relationship:** _____

Current Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Seeking Employment ☐ Student ☐ Other _____

Occupation: _____

Previous Volunteer Experience: _____

Relevant Skills/Experience: _____

Bilingual? ☐ Yes ☐ No **If yes, which language(s):** _____

How did you hear about Trinity Community Care? _____

Church/Ministry affiliation (if any)? _____

What volunteer opportunity are you interested in? (Check all that apply):

☐ Doctor	☐ Physician Assistant	☐ Nurse Practitioner	☐ Registered Nurse	☐ LPN
☐ Medical Assistant	☐ Dentist	☐ Hygienist	☐ Dental Assistant	☐ Prescription Assistance
☐ Pharmacist	☐ Pharmacy Tech	☐ Social Worker	☐ Eligibility Specialist	☐ Resource Coordinator
☐ Administrative Support	☐ Scheduling	☐ Front Desk	☐ Data Entry	☐ Clerical
☐ Bookkeeping/Acctg	☐ Technology/Computers	☐ Fundraising	☐ Grant Writing	☐ Marketing
☐ Prayer/Spiritual Support	☐ Cleaning/Maintenance	☐ Event Planning/ Events	☐ Other: _____	

Professional Registration/License Information (Where applicable):

MI License Number: _____ **Expiration Date:** _____ **Specialty:** _____

Do you have your own malpractice coverage? ☐ Yes ☐ No **If yes, note carrier:** _____

Are you currently employed as a clinical provider? ☐ Yes ☐ No **If yes, where?** _____

Current hospital privileges: _____

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Which days of the week and times are you able to volunteer?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

How often would you like to volunteer?

☐ Once a week ☐ Every two weeks ☐ Once a month
☐ Every 2-3 months ☐ Special Events/Projects ☐ Other: _____

How long of a commitment are you prepared to make? ☐ Short-term ☐ 6 months-1 year ☐ Longer than a year

Have you ever been convicted or plead guilty to any crime(s) other than minor traffic violations?

☐ Yes ☐ No If yes, please explain: _____

VOLUNTEER APPLICANT ACKNOWLEDGEMENT & RELEASE

I hereby certify that the information provided by my on this Volunteer Application is accurate to the best of my knowledge and may be subject to verification by Trinity Community Care. As a condition of volunteering, I give permission to Trinity Community Care to conduct a background check on me, including criminal history records, which may be repeated at any time while I remain a volunteer. I hereby release and agree to hold harmless Trinity Community Care, its officers, agents, employees and volunteers, or any other person associated with Trinity Community Care. I also understand that Trinity Community Care is not obligated to appoint me to a volunteer position. If appointed, I understand that I am subject to the policies and procedures of Trinity Community Care. I also understand that said appointment to a volunteer position is considered "at will"; therefore, I may be terminated for any reason or no reason, with or without notice. I further understand that I have no recourse whatsoever against Trinity Community Care, its officers, agents, employees, or volunteers for any action taken for or against me as a result of, or in connection with my volunteer work, regardless of the intent of the person taking such action.

Signature: _____ **Date:** _____

Our Mission:

Trinity Community Care provides free medical and dental care to those who cannot afford it, delivered with unconditional Christian love. We strive to do this in an integrated manner to create positive health outcomes.

"Whatever you did for one of the least of these brothers and sisters of mine, you did for me." Matthew 25:40

APPLICANT REFERENCE CHECKLIST

Please include the following documentation when submitting your application:

☐ Completed/Signed Application ☐ Copy of Driver's License, State ID, or Passport

For clinical positions:

Have you had the Hepatitis B vaccination series? ☐ Yes ☐ No **Do you have a current PPD skin test?** ☐ Yes ☐ No

Please also include copies of your:

☐ Health License or Certification ☐ DEA Certificate (if applicable) ☐ NPI Number (if applicable)
☐ ACLS/BLS Card (if applicable) ☐ Malpractice Policy Cover Sheet (if applicable)

Documentation provided will be kept on file with Trinity Community Care for auditing purposes.