

# 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):**

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Doctor                   | <input type="checkbox"/> Physician Assistant  | <input type="checkbox"/> Nurse Practitioner     | <input type="checkbox"/> Registered Nurse       | <input type="checkbox"/> LPN                     |
| <input type="checkbox"/> Medical Assistant        | <input type="checkbox"/> Dentist              | <input type="checkbox"/> Hygienist              | <input type="checkbox"/> Dental Assistant       | <input type="checkbox"/> Prescription Assistance |
| <input type="checkbox"/> Pharmacist               | <input type="checkbox"/> Pharmacy Tech        | <input type="checkbox"/> Social Worker          | <input type="checkbox"/> Eligibility Specialist | <input type="checkbox"/> Resource Coordinator    |
| <input type="checkbox"/> Administrative Support   | <input type="checkbox"/> Scheduling           | <input type="checkbox"/> Front Desk             | <input type="checkbox"/> Data Entry             | <input type="checkbox"/> Clerical                |
| <input type="checkbox"/> Bookkeeping/Acctg        | <input type="checkbox"/> Technology/Computers | <input type="checkbox"/> Fundraising            | <input type="checkbox"/> Grant Writing          | <input type="checkbox"/> Marketing               |
| <input type="checkbox"/> Prayer/Spiritual Support | <input type="checkbox"/> Cleaning/Maintenance | <input type="checkbox"/> Event Planning/ Events | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 me 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.