



# Volunteers in Medicine

OF MONROE COUNTY

[vimmonroecounty.org](http://vimmonroecounty.org)

## Volunteer Application Form

Today's Date: \_\_\_\_\_ [For office use only PIN: \_\_\_\_\_]

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth (optional): (month/day/year) \_\_\_\_\_

Are you employed? (circle one) NO or YES

Employer: \_\_\_\_\_

Have you ever volunteered anywhere else? (circle one) NO or YES

If yes, where and for how long?

\_\_\_\_\_  
\_\_\_\_\_

Level of Education/Degrees Held: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Licenses/Certifications: \_\_\_\_\_

\_\_\_\_\_

Do you speak any foreign languages? (circle one) NO or YES

If yes, what language(s)? \_\_\_\_\_

Skill Level: Fluent: \_\_\_\_\_ Conversational: \_\_\_\_\_ Language: \_\_\_\_\_

Skill Level: Fluent: \_\_\_\_\_ Conversational: \_\_\_\_\_ Language: \_\_\_\_\_

List special skills/experience you would bring to this organization: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of a crime (felony or misdemeanor)? (circle one) NO or YES

If yes, please explain in detail: \_\_\_\_\_

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Why would you like to volunteer at Volunteers in Medicine of Monroe County?

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Are you mandated to perform volunteer hours? Is this for class credits? (circle one) NO or YES

How many hours? \_\_\_\_\_ By whom: \_\_\_\_\_

What are your hobbies and interests? \_\_\_\_\_

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How did you hear of this organization? \_\_\_\_\_

**Clinic Hours/Shifts: M, T, W, Th, F; 8am to noon; 1pm to 5 pm; M & Th; 5pm to 8 pm.**

What shifts are you available to volunteer? Please list the periods that you are available.

Mon: \_\_\_\_\_

Tues: \_\_\_\_\_

Wed: \_\_\_\_\_

Thurs: \_\_\_\_\_

Fri: \_\_\_\_\_

Total Hours you would like to volunteer: \_\_\_\_\_ (circle one) WEEKLY or BI-WEEKLY

Are there are any exceptions or conflicts with the above hours? (circle one) NO or YES

If yes, please list them:

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Please let us know your **top 3 choices** for a volunteer position with the clinic (#1 being your first choice):

- \_\_\_\_\_ Greeters
- \_\_\_\_\_ Receptionists
- \_\_\_\_\_ Eligibility Interviewers
- \_\_\_\_\_ Appointment Schedulers
- \_\_\_\_\_ Data Entry Volunteers
- \_\_\_\_\_ Interpreters (Spanish)
- \_\_\_\_\_ Medical Record Volunteers
- \_\_\_\_\_ Clerical Assistants
- \_\_\_\_\_ Medication Room Volunteers
- \_\_\_\_\_ Dental Assistants
- \_\_\_\_\_ Nursing Receptionists
- \_\_\_\_\_ Community Outreach Volunteers
- \_\_\_\_\_ Event Planning Volunteers
- \_\_\_\_\_ Other

Please provide two references (please do not include relatives):

1. Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ How long have you known this person? \_\_\_\_\_  
What would this person say about you?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ How long have you known this person? \_\_\_\_\_  
What would this person say about you?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I certify that all the statements herein on this volunteer information sheet are true and correct and have been given voluntarily. I understand that this information may be shared with any legal and proper interest, and I release the agency from any liability whatsoever for supplying such information. I understand I will not be paid for my services in my volunteer capacity. I agree to abide by Volunteer in Medicine of Monroe County's policies and procedures.**

**I also allow Volunteers in Medicine of Monroe County to use my picture(s) and/or comments for newsletters, public relations mailings and any other Volunteers in Medicine related, legitimate purpose.**

Applicant Signature \_\_\_\_\_

Date: \_\_\_\_\_

# Confidentiality Statement

Due to the nature of this organization, Volunteers in Medicine of Monroe County require that all volunteers sign a confidentiality agreement. By signing below, you agree to adhere to this policy:

I shall hold in confidence all pertinent information. I will not violate the confidential relationship between Volunteers in Medicine of Monroe County and its patients, donors, staff, volunteers, and any other party. I will not remove any written record from Volunteers in Medicine of Monroe County without expressed written permission and I will not discuss patient or any other sensitive information with anyone, except in the performance of my duties with Volunteers in Medicine of Monroe County.

I will accept full responsibility for my actions in maintaining the confidential and privileged nature of all records and information. I also understand that disclosing information will result in immediate action up to and including dismissal from my volunteer position.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# Emergency Information

***Please Print Clearly***

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

In the event of an emergency, please notify this person:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Alternate Contact for emergencies:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Do you have any medical conditions or limitations that might affect your ability to perform the volunteer duties, or that Volunteers in Medicine of Monroe County should be aware of?

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_