



Volunteer Application

For Staff Use Only

Entered	Reviewed By:	____/____/____
Follow-up	Pursue as Volunteer:	Yes / No
Orientation	Last Date Worked:	____/____/____
Date of Licensing:		____/____/____

Contact Information

Name: _____

Preferred Nickname: _____ Date of Birth ____/____/____

E-mail: _____ (CVFC conducts 90% of volunteer communication by email)

Address: _____ City, State _____

Zip Code: _____ Home Phone: _____

Cell Phone: _____ Business Phone: _____

Preferred method of phone contact: (please check one) ____ Cell Phone ____ Business Phone ____ Home Phone

Preferred time to be contacted: (please check one) ____ Morning ____ Afternoon ____ Evening ____ Anytime

Emergency Contact Information

Name: _____ Relationship: _____

Phone: _____

Employment Information

I am: (please check those that apply) ____ Employed ____ Un-employed ____ Retired ____ Student @ _____

Current Employer: _____ Occupation: _____

Contact Telephone Number: _____

Preferred availability (Check all that apply): ____ Evening ____ Daytime ____ Tuesdays ____ Thursdays ____ Flexible

Volunteer Position Desired

Medical Clinic

____ Clinician (Physician, Nurse Practitioner) ____ Registered Nurse ____ Certified Lab Technician
____ Pharmacist ____ LPN/ Medical Assistant ____ Social Worker ____ Registered Dietitian ____ Receptionist

Administration

____ Administrative Assistance (data entry, spreadsheets, writing, scheduling)
____ Technical Skills (technical and public relations writing, web-site and media design, statistics and analytics)
____ Special Projects (fundraising, work projects, special events)
____ Building Maintenance (cleaning, projects)

Special Expertise (knowledge of computers, foreign languages, grant writing, etc.): _____

____ Other _____

Name: _____ (Last, First, MI)

Educational Training/ Licenses or Certifications (list all applicable specialties, degrees, and credentials):

Information Requested from Medical Staff only

Please answer the following questions that apply to you and attach details for all YES responses

YES NO

Have any of your licenses or certificates to practice ever been restricted, revoked, suspended, limited, surrendered or canceled, or has there been any other disciplinary action against your licenses or certificates?

National Provider Identification Number _____ (if applicable)

Personal Information

Do you have any limitations or medical conditions we should be aware of? ____ No ____ Yes

If yes, please explain: _____

Have you ever been convicted of a felony? ____ No ____ Yes

If yes, please explain: _____

What do you want to accomplish at CVFC? _____

Why volunteer at CVFC? (vs. Community Table, Literacy Volunteers, etc.) _____

How did you hear about CVFC? _____

Please indicate any questions you might have for us: _____

Confidentiality

I, the undersigned, understand and agree to the following as a volunteer of the Chippewa Valley Free Clinic:

I am aware that I will come in contact with confidential information and that it is my responsibility to maintain this confidentiality in accordance with the CVFC policies and procedures. I further understand that in the case of breach of confidentiality, I should expect termination from the volunteer program.

I certify that: (1) The above information is complete and correct, and (2) I understand and agree with the confidentiality statement.

Signature _____ Date _____



The Chippewa Valley Free Clinic mission is to provide health services and advocacy for the people of the Chippewa Valley who have no health care alternative.

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Updated:
11/1/2011
2:53 PM