

# DOCTORS OF THE WORLD ROCKAWAYS FREE CLINIC



## Volunteer Application

### PLEASE PRINT

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Street \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

Date of birth \_\_\_\_\_

Physical Limitations: No  Yes  (Please Explain \_\_\_\_\_)

*(for Clinicians only):* License number \_\_\_\_\_ DEA \_\_\_\_\_

Education (highest level completed): \_\_\_\_\_

Current work/occupation \_\_\_\_\_ Most recent employer \_\_\_\_\_

Previous volunteer experience \_\_\_\_\_

Please list two references with contact info (at least one professional for nurses, MAs, clinicians)

1 Reference \_\_\_\_\_ Contact \_\_\_\_\_

2 Reference \_\_\_\_\_ Contact \_\_\_\_\_

Skills (List your relevant skills and indicate proficiency level—skilled, can teach, amateur)

1 Skill \_\_\_\_\_ Level \_\_\_\_\_

2 Skill \_\_\_\_\_ Level \_\_\_\_\_

3 Skill \_\_\_\_\_ Level \_\_\_\_\_

Volunteer availability: (Check all applicable)

Number of 4 hour sessions per month: 1  2  3  4  5  >5

Monday  AM / PM

Friday  AM / PM

Tuesday  AM / PM

Saturday  AM / PM

Thursday  AM / PM

No Preference

\*Please note that current clinic sessions are: Thurs 10-2PM, Thurs 2-6PM, Sat 10-2PM

**In the event of an emergency, please contact:**

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

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

**Volunteers hereby agree to serve any client who is assigned regardless of gender, race, ethnicity, religion, age, political beliefs or sexual orientation.**

(Signature/Volunteer) \_\_\_\_\_ (Date) \_\_\_\_\_

*(if unable to transmit with original signature, form may be signed in person at start of volunteer assignment)*

**What is your motivation for volunteering with the Doctors of the World Rockaways Free Clinic?**

*(please attach additional sheets if needed)*