Mission Medical Clinic Volunteer Application

The purpose of Mission Medical Clinic is **"*Healing the Sick in the name of Jesus.*"**

ORIENTATION DATE __________________

Have you, or a family member, been a patient at MMC? Yes___ No__ If yes, date discharged.________

Please Print: Name: ___________________________________ Birth date: _____________________

Preferred Name: _________________ Church currently attending: ______________________________

Home Address: ____________________________________City_____________________ Zip: _______

Phone: (H) (____) __________ (W) (____) ___________ (Cell) (____)___________

E-mail Address: ____

Professional License #: ________ active: Yes ___No___ Expires__________

Education: Grade Completed _______ Years of college __________major______________________

Technical Education or degree ______________________Advanced Education_____________________

Work Experience: (specific tasks) ____

Current Employer: ________ ____

Volunteer Experience/Expertise: ____

____

Personality Traits (top two): ____ ______

____

Volunteer Interests:

Medical Clinic: MD___PA___NP___RN___LPN__RPh___PhT__Administrative _______

Dental Clinic: DDS___Dent Hyg ___Dent Asst____Administrative _______

Prayer Minister_____ Behavioral Health Counselor ____ Administrative ______

Pharmaceutical/Dispensary RxA___ Administrative ________

Vision: Optom ______ Administrative __ IT/Computer Support_______ Network Support __________

Admissions_____ Med Records_________Receptionist ________________

Communications ________ Social Media ___________ Fundraising ______ Special Events _________

Meal Provider ________Data Entry________ Office Work ________

Landscaping ______Cleaning & Maintenance_______

Other ____

Availability ____ I can start:________________________

Matthew 25:40 "Inasmuch as you did it to one of the least of these My brethren, you did it to Me."

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Why do you want to volunteer at the Mission Medical Clinic? ______________________________

____

Emergency Contact: ____

Relationship: ______________________________ Phone: ______________________________

Mission Medical Clinic invites you to list any medical conditions or allergies you want us to be aware of, even though these conditions do not now impair your ability to perform as a volunteer in the Clinic. For your protection we would like the name of your primary physician. This information will be used only if you require health assistance on an urgent or emergency basis while volunteering at the Clinic.

Medication, Insect or Food Allergy: ____

Type of allergic reaction: ____

Physical Limitations: ____

Medical Conditions: ____

Primary Physician: ________________________________ Phone: ___________________

Please provide the information below of three references (No family members please; work, neighbor, or friend).

- Name:____________________Phone:____________**EMAIL**_________________________
- Name:____________________Phone:____________**EMAIL**_________________________
- Name:____________________Phone:____________**EMAIL**_________________________

I agree to have a Criminal Background Investigation known as a CBI done for legal purposes for the clinic.

I attest that I currently am free of any physical or mental conditions that would impair my ability to perform the functions I agree to as a volunteer of the Mission Medical Clinic. I give Mission Medical Clinic permission to contact the references listed above. I also attest that I am free from addiction to drugs, alcohol, or any other recreational chemical substance. I understand that I may not hold Mission Medical Clinic responsible for any condition, which I have disclosed or not disclosed.

Signature: ____________________________________ Date: __________________

Opportunities for volunteers are provided without regard to race, color, national origin, gender, sexual orientation, religion, age, or disability.

Revised March 7, 2015