



## Volunteer Application v2015

Applicant's name:		Date of Birth (MM/DD/YY):	
Mailing Address:		City:	Zip:
Home Phone: (     )		Alternate (work/mobile): (     )	
Emergency Contact:		Phone:	Relation:
Email:		Professional License #:	

Please check the areas that you are interested in volunteering for

**MEDICAL**

Do you have a current certification and/or license in the state of Wisconsin for: (Check if applicable)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Physician            | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Dentist          | <input type="checkbox"/> Psychiatrist       |
| <input type="checkbox"/> Physician Assistant  | <input type="checkbox"/> Registered Nurse   | <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Counselor          |
| <input type="checkbox"/> Pharmacist           | <input type="checkbox"/> Medical Assistant  | <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Chiropractor       |
| <input type="checkbox"/> Pharmacy Technician* | <input type="checkbox"/> Lab Technician     | <input type="checkbox"/> Optometrist      | <input type="checkbox"/> Physical Therapist |

\*Supervising Pharmacist WI Pharmacist Lic. # \_\_\_\_\_  Other Medical \_\_\_\_\_

Most health care professionals listed above will be enrolled in the Volunteer Health Care Provider Program (Wisconsin statute ch. 146.89) for additional liability coverage. If not listed above, do you carry private malpractice insurance? Y/N

**NON-MEDICAL**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Clerical        | <input type="checkbox"/> Data entry       | <input type="checkbox"/> Receptionist    | <input type="checkbox"/> Technical / Trade: |
| <input type="checkbox"/> Intake screener | <input type="checkbox"/> Patient Advocacy | <input type="checkbox"/> Case Management | _____                                       |
| <input type="checkbox"/> Housekeeping    | <input type="checkbox"/> Interpreter      | <input type="checkbox"/> Maintenance     |   |
| <input type="checkbox"/> Fundraising     | <input type="checkbox"/> Bookkeeping      | <input type="checkbox"/> Marketing       |   |
| <input type="checkbox"/> Other:          | _____                                     |  |   |

Do you speak/read Spanish? Yes \_\_\_ No \_\_\_ Additional Languages \_\_\_\_\_

Availability: Weekly \_\_\_\_\_ Twice monthly \_\_\_\_\_ Monthly \_\_\_\_\_ Other: \_\_\_\_\_

**AUTHORIZATION & RELEASE** I certify that the information I have provided is complete & accurate to the best of my knowledge. I release from any liability representatives of the Open Arms Free Clinic (CLINIC) for their acts in connection with evaluating my application, references and credentials. I understand that the position I am applying for is voluntary and for which there will be no monetary compensation. I authorize CLINIC and/or their agent to investigate my background including my professional, criminal and driving history and hereby release said information to them. I further release and discharge from liability CLINIC, their agents, employees, officers and other persons from all liability arising from the investigation or disclosure of the requested information, as well as those companies, agencies, officials, officers, employees and other persons, who in good faith provide this information to CLINIC and/or its agents. I will allow a photocopy of authorization to be as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Complete and return to:  
 EMAIL: [info@openarmsfreeclinic.org](mailto:info@openarmsfreeclinic.org) or  
 MAIL: Open Arms Free Clinic ATTN: Volunteer Coordinator; P.O. Box 678, Elkhorn, WI 53121