Helen M. Nickless
VOLUNTEER CLINIC

VOLUNTEER APPLICATION

LAST NAME	**FIRST NAME**	**MIDDLE INT**	☐ RN ☐ LPN ☐ MA ☐ CNA ☐ OTHER _____	
DO YOU PREFER A NICKNAME	**WOULD YOU PREFER TO BE CONTACTED BY:** ☐ WORK PHONE ☐ HOME PHONE ☐ CELL PHONE ☐ EMAIL		**MARITAL STATUS** ☐ SINGLE ☐ DIVORCED ☐ LEGALLY ☐ MARRIED ☐ WIDOWED SEPARATED	
ADDRESS STREET	**CITY**	**STATE**	**ZIP**	**DATE OF BIRTH**
HOME PHONE ( )	**WORK PHONE** ( )		**CELL PHONE** ( )	
PAGER ( )	**E-MAIL ADDRESS**			

HAVE YOU EVER BEEN A VOLUNTEER? ☐ YES ☐ NO

WHEN? (APPROX) **WHERE?**

ARE YOU AWARE OF ANY MEDICAL, PHYSICAL OR MENTAL HANDICAP THAT WOULD AFFECT YOUR ABILITY TO PERFORM VOLUNTEER DUTIES? ☐ YES ☐ NO

EXPLAIN: _____

ARE YOU PRESENTLY EMPLOYED BY OR CONNECTED WITH BAY REGIONAL MEDICAL CENTER OR OTHER McLAREN AFFILIATE?
☐ YES ☐ NO. IF YES, EXPLAIN BELOW (Affiliate Name, ie, VNSM, MMMI)

ARE YOU PREPARING FOR ANY SPECIAL CAREER? ☐ YES ☐ NO. IF YES, DESCRIBE BELOW.

EDUCATION
☐ HIGH SCHOOL ☐ COLLEGE ☐ OTHER:

ARE YOU PRESENTLY A STUDENT? ☐ YES ☐ NO IF YES, WHERE:

DO YOU HAVE TRAINING/EXPERIENCE IN ANY SPECIAL AREA? ☐ YES ☐ NO. IF YES, DESCRIBE BELOW.

PLEASE LIST ANY SPECIAL SKILLS OR ABILITIES YOU POSSESS
☐ COMPUTER ☐ FUNDRAISING ☐ FILING ☐ OTHER:

_____

DO YOU SPEAK A FOREIGN LANGUAGE? ☐ YES ☐ NO IF YES, WHICH ONES:

COMMUNITY AFFILIATIONS

_____

ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO	**MAY WE CONTACT YOU AT WORK** ☐ YES ☐ NO	
CURRENT EMPLOYER	**PHONE NUMBER**	**DATES OF EMPLOYMENT**
PREVIOUS EMPLOYER	**PHONE NUMBER**	**DATES OF EMPLOYMENT**

OVER

REFERENCES (Other Than Relatives)

NAME			PHONE NUMBER	
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP**
NAME			**PHONE NUMBER**	
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP**

EMERGENCY CONTACT

NAME			PHONE NUMBER	
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP**

ASSIGNMENT PREFERENCES

CLINIC NIGHT - WEDNESDAYS

- ☐ **CLINICAL** 5:00 pm - closing
- ☐ **PHARMACY** 6:00 pm - closing
- ☐ **INTAKE (INTERVIEWS)** 4:45 pm - 7:00 pm
- ☐ **FRONT OFFICE** 4:30 pm - 8:30 pm
- ☐ **GREETER** 4:30 pm - 7:00 pm

(Approximate Times)

ALTERNATE SERVICE AREAS (Approximate time)

- ☐ **CHART REVIEW** Thursdays 9:30 am – 11:30 am
- ☐ **OFFICE WORK** Variable times
- ☐ **FUND RAISING** Variable times
- ☐ **EVENTS** Variable times
- ☐ **OTHER AREAS OF INTEREST** (LIST BELOW)

_____

_____

Would you like to be scheduled to work with a friend or group (i.e. Co-workers, Church group, etc)?

For your protection and that of our patients
ALL VOLUNTEERS ARE REQUIRED TO HAVE A TB SKIN TEST
Or proof that they have had a test within the past year.

IF YOU ARE NOT A MCLAREN AFFILATE

HAVE YOU HAD A TB SKIN TEST IN THE PAST YEAR? ☐ YES ☐ NO
If yes, please submit proof along with this application.

This test is available at Bay Regional Medical Center's (BRMC) Employee Health at no charge to volunteers.
For further information please call (989) 894-3158

HAVE YOU HAD HIPAA TRAINING? ☐ YES ☐ NO
If yes, please submit proof along with this application.

SIGNATURE	DATE
X	