Helen M. Nickless
VOLUNTEER CLINIC

PROFESSIONAL VOLUNTEER APPLICATION

LAST NAME	**FIRST NAME**	**MIDDLE INT**	☐ MD ☐ DO ☐ PA ☐ NP ☐ RPh ☐ DDS ☐ OTHER _____
SPECIALTY	**WOULD YOU PREFER TO BE CONTACTED BY:** ☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ PAGER ☐ E-MAIL		**MARITAL STATUS** ☐ SINGLE ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ MARRIED ☐ WIDOWED
ADDRESS **STREET**	**CITY**	**STATE** **ZIP**	**DATE OF BIRTH**
HOME PHONE ( )	**WORK PHONE** ( )		**CELL PHONE** ( )
PAGER ( )	**E-MAIL ADDRESS**		

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

EXPLAIN: _____

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

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

CURRENT WORK SITE (PRACTICE/PHARMACY NAME)

ARE YOU PRESENTLY CONNECTED WITH BAY REGIONAL MEDICAL CENTER OR OTHER McLAREN AFFILIATE?

☐ YES ☐ NO **IF YES, EXPLAIN BELOW:**

ARE YOU CURRENTLY ON STAFF AT BAY REGIONAL MEDICAL CENTER? ☐ YES ☐ NO

ARE YOU CURRENTLY ON STAFF AT A HOSPITAL OTHER THAN BAY REGIONAL MEDICAL CENTER? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE NAME OF HOSPITAL:

HAVE YOU EVER BEEN DENIED HOSPITAL PRIVILEGES OR BEEN ASKED TO GIVE UP PRIVILEGES? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ON A SEPARATE PAPER.

OVER ⇨

PROFESSIONAL REFERENCES

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

Would you like to be scheduled to work with a friend or group (i.e. Co-workers, Church group, etc)?
☐ **YES** ☐ **NO** **IF YES, PLEASE LIST PREFERENCES BELOW:**

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.

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

PRACTITIONERS/DENTISTS

If you are a licensed practitioner and not on staff at Bay Regional Medical Center or Bay Special Care Hospital, please submit copies of the following:

- ❑ **Professional licenses**
- ❑ **C.V.**
- ❑ **Diploma(s)**

PHARMACISTS

If you are a licensed pharmacist and not on staff at Bay Regional Medical Center or Bay Special Care Hospital, please submit copies of the following:

- ❑ **Michigan Professional Licenses**

SIGNATURE BELOW IMPLIES PERMISSION TO CREDENTIAL

SIGNATURE	DATE
X	