HOPE CLINIC

VOLUNTEER APPLICATION

Bringing Health and Hope Within Reach

Thank you for your interest in volunteering with Hope Clinic. Please complete this application so we can identify opportunities that match your interests, experience, qualifications, and availability.

CONTACT INFORMATION

Full Name: _____

Preferred Name: _____ **Credentials/Degree (if applicable):** _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Cell Phone: _____ **Email:** _____

Preferred Method of Contact: ☐ Phone/Call ☐ Text ☐ Email

ABOUT YOU

Current or Former Occupation: _____

Current Employer/Organization (if applicable): _____

Are you currently a student? ☐ Yes ☐ No **School/Program:** _____

Field of Study: _____

Do you speak another language? ☐ Yes ☐ No **Language(s):** _____

Please tell us about any previous volunteer experience.

_____

_____

VOLUNTEER INTERESTS *Please check all areas that interest you. You may select more than one.*

Clinical & Healthcare

☐ Physician - MD/DO ☐ Nurse Practitioner ☐ Physician Assistant ☐ Registered Nurse

☐ Licensed Practical Nurse ☐ CMA/CNA/Medical Assistant ☐ Phlebotomist/Lab Tech. ☐ Pharmacist

☐ Pharmacy Technician ☐ Licensed Social Worker/Therapist ☐ Recovery Support (CPSS, CDAC)

☐ Registered Dietitian/Diabetes Educator ☐ Other Healthcare Professional: _____

Clinic Support

☐ Front Desk/Patient Support ☐ Patient Eligibility/Enrollment ☐ Administrative Support

☐ Spanish/Language Interpretation ☐ Patient Transportation

Community & Organizational Support

☐ Community Outreach ☐ Special Events/Fundraising ☐ Marketing/Communications

☐ Photography/Graphic Design ☐ Grant Writing ☐ Technology/IT Support

☐ Board or Committee Service ☐ Other: _____

SKILLS & EXPERIENCE

Please tell us about any skills, professional experience, training, certifications, hobbies, or other talents you would be interested in sharing with Hope Clinic.

_____

_____

HEALTHCARE PROFESSIONALS ***Please complete this section if you are interested in a clinical, pharmacy, or other professional healthcare volunteer position.***

Profession/Title: _____

Specialty/Area of Practice: _____

Current Practice Status: ☐ Currently Practicing ☐ Retired ☐ Other: _____

AVAILABILITY

When are you generally available? Check all that apply.

Day	Morning	Afternoon	Evening
Monday	☐	☐	☐
Tuesday	☐	☐	☐
Wednesday	☐	☐	☐
Thursday	☐	☐	☐
Friday	☐	☐	☐
Saturday/Special Events	☐	☐	☐

How often would you like to volunteer? ☐ Weekly ☐ Twice Monthly ☐ Monthly

☐ Occasionally/As Needed Other:_____

REFERENCE

Please provide one professional or personal reference who is not an immediate family member.

Name: _____

Relationship: _____ **Phone:** _____

How did you hear about volunteer opportunities at Hope Clinic?

☐ Hope Clinic Website ☐ Social or Printed Media ☐ Current Volunteer/Staff Member

☐ Friend or Family Member ☐ School/College☐ Healthcare Organization ☐ Community Event

☐ Other: _____

Are you willing to complete orientation and training required for your volunteer role? ☐ Yes ☐ No

APPLICANT CERTIFICATION

I certify that the information provided in this application is accurate to the best of my knowledge. I understand that applying does not guarantee placement as a Hope Clinic volunteer and that additional information, documentation, or training may be required depending on my volunteer role.

Applicant Name: _____ **Date:** _____

Signature: _____