COMMUNITY HEALTH CLINIC

120 S. Central Expressway, Ste. 102, McKinney, TX 75070 * PHONE: (972) 547-0606 * FAX: (972) 547-0851 * www.chc-mckinney.com

VOLUNTEER APPLICATION

Please PRINT clearly!

Full Name:_____ Preferred Name:_____ Date:_____

Home:_____ Cell: _____ E-Mail:_____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ E-Mail ☐ Any

Mailing Address:_____City/State:_____ Zip:_____

EMPLOYMENT, TRAINING & EDUCATION

Please attached your resume or professional CV and complete the following:

Check one (or more) of the following: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

MOST RECENT PROFESSIONAL EMPLOYMENT/PRACTICE HISTORY

Date Started	Date Ended	Employer	Position

EDUCATION – *indicate the name of the institution, program and year completed*

High School:_____ City/St:_____Year:_____

Postsecondary:_____Program/Degree:_____Year:_____

Graduate/Professional:_____Program/Degree:_____Year:_____

Licenses/Certifications (list applicable degrees & credentials):

LICENSED PROFESSIONALS ONLY – *ATTACH PHOTOCOPY OF PROFESSIONAL LICENSURE*

1) License type and #:_____NPI#:_____
2) Has your professional license ever been restricted in any way? YES or NO (circle one) If YES, attached documentation.
3) Are you involved in any ongoing litigation pertaining to professional activities? YES OR NO (circle one) If YES, attached documentation.
4) Do you have prescriptive authority? YES or NO (circle one)

SERVICE OPPORTUNITIES

What volunteer opportunities interest you at the Community Health Clinic?

MEDICAL CLINIC	ADMINISTRATION	SKILLS	SPECIAL PROJECTS
___Nurse Practitioner*	___Front office clerical	___Computer	___Fundraising
___Registered Nurse*	___Translator	___Filing/Organizational	___Event Coordinator
___Medical Assistant*	___Intern	___Social Media	___Other
___Student Nurse	Languages:	___Grant Writing	_____
___Student NP	_____	___Marketing	_____
___Dietitian*	_____		

*Position requires appropriate professional training or certification.

Have you volunteered at the Community Health Clinic before? If yes, when?

Why do you want to volunteer, and what do you hope to gain from serving the Community Health Clinic?

Is there anything else you would like to know about you (i.e., career goals, special needs, etc.)?

Frequency of Service? ☐ 1-2 times per month ☐ once a week ☐ several times/week

Time Commitment? 3 months ☐ 6 months ☐ school year ☐ 1 year ☐ more than 1 year

Please indicate the time slots you are available for volunteer service

	Monday	Tuesday	Wednesday	Thursday	Friday
Day Clinic 8:30am-2:00 pm			Closed		
Evening Clinic 5:00pm-7:00pm	Closed				Closed

By signing below, I certify that the information I have provided in this application is accurate and true to the best of my knowledge, and that no assertions have been falsified.

Signature of Applicant:_____ Date:_____

Note: The Community Health Clinic reserves the right to decline volunteer assistance, when necessary. Completed volunteer applications and written qualifications do not guarantee an individual's placement within the organization's volunteer program. Selection and appropriateness for all volunteer positions will be at the discretion of the department directors.

<<FOR OFFICE USE ONLY>>

NOTES:

Executive Director Approval:_____ Date:_____