



The Free Medical Clinic of Greater Cleveland

12201 Euclid Avenue ♦ Cleveland, Ohio 44106-4399 ♦ PHONE: (216) 721-4010 ♦ FAX: (216) 707-3530 ♦ www.TheFreeClinic.org

♦ VOLUNTEER APPLICATION ♦

Dear Prospective Volunteer:

Thank you for expressing an interest in volunteering at The Free Medical Clinic of Greater Cleveland. We take great pride in the success of our organization, but we could not be as productive and effective as we are without the outstanding efforts of our amazing volunteers!

Please submit your volunteer packet when you have completed the double-sided application, obtained two professional references (in sealed and signed envelopes for confidentiality), and provided copies of current professional licenses and/or certifications (if required). To avoid confusion, please refrain from submitting references separately from your application. References are required of all applicants.

Applications may be dropped off at the front desk or mailed to The Free Clinic:

**Volunteer Department
The Free Medical Clinic of Greater Cleveland
12201 Euclid Avenue
Cleveland, OH 44106**

After submitting your application, please allow approximately **two weeks** for processing. You may then be contacted to arrange an interview or to be placed on the waiting list. We will keep your application on file for up to six months without activity.

We assure you that your dedication as a volunteer will be greatly appreciated by our staff and patients. Volunteers keep the FREE in The Free Clinic! As a volunteer, you will gain an experience unparalleled while working alongside our remarkable staff and volunteers in our beautiful facilities. We appreciate your interest and look forward to welcoming you to The Free Clinic's team!

**** PLEASE KEEP THIS FRONT PAGE FOR YOUR REFERENCE. ****



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VOLUNTEER APPLICATION

Please PRINT clearly!

When completed, return (with references) to the Volunteer Office.

Full Name: _____ Preferred Name: _____ Date: _____

Home: _____ Cell: _____ Work: _____ E-Mail: _____

Preferred method of contact: Home Cell Work E-mail Any

Mailing Address: _____ City/State: _____ Zip: _____

EMPLOYMENT, TRAINING, & EDUCATION

Please attach your **resume** or **professional CV**, and complete the following:

Check one (or more) of the following: Employed Un-employed Retired Student

Employer _____ Occupation _____

Employer Address _____ Phone _____

Most Recent Professional Employment / Practice History

Date Started	Date Ended	Employer	Position & Responsibilities

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, attach documentation.

3) Are you involved in any ongoing litigation pertaining to professional activities? **YES** or **NO** (circle one) If YES, attach documentation.

4) Do you have prescriptive authority? **YES** or **NO** (circle one)

FOR STATISTICAL PURPOSES ONLY – please complete

Date of Birth: _____ Race: _____ Gender: _____ Languages spoken: _____

◆ How did you hear about our needs at The Free Clinic? (Circle all that apply) Friend Print ad Word of Mouth

Current Volunteer: _____ Association/Club: _____ Website: _____

SERVICE OPPORTUNITIES

What volunteer opportunities interest you at The Free Clinic? Please rank your interests by number.

<p>MEDICAL CLINIC</p> <p>___ Intake Worker ___ Chap Specialist ___ Nurse Practitioner* ___ Pharmacist* ___ Pharmacy Assistant ___ Registered Nurse* ___ U.S. Licensed Physician*</p>	<p>ADMINISTRATION</p> <p>___ Admin/Clerical Support Worker ___ Advocacy Support Worker ___ Associate Board Member ___ Client Service Representative ___ External Affairs Support Worker</p>	<p>BEHAVIORAL HEALTH</p> <p>___ Chemical Dependency Counselor* ___ Clerical Aide ___ Clinical Consultant* ___ Clinical Supervisor* ___ Internship/Practicum* ___ Patient Asst. Prog. Ambassador ___ Psychiatrist* ___ Psychiatry Resident* ___ Social Service Intake Worker ___ Therapist* ___ Nurse Practitioner Resident*-BH rotation</p>
<p>HIV CLINIC</p> <p>___ HIV Intervention Specialist ___ Syringe Exchange Program Worker ___ Community Outreach Educator</p>	<p>DENTAL CLINIC</p> <p>___ Dental Aide ___ Dental Assistant* ___ Dental Student* ___ Dental Hygienist* ___ U.S. Licensed Dentist*</p>	<p>SPECIAL PROJECTS</p> <p>Other _____ _____ _____</p>
<p>* Position requires appropriate professional training or certification</p>		

- ◆ Have you volunteered at The Free Clinic before? If yes, when?
- ◆ Why do you want to volunteer, and what do you hope to gain from serving at The Free Clinic?
- ◆ Is there anything else you would like us to know about you (i.e., career goals, special needs, etc.)?

Frequency of service? 1-2 times per month every other week 1x/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	Saturday	Sunday
Mornings							closed
Afternoons							
Evenings					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 Free 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:



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Volunteer Professional Reference Check Form

Volunteer applicant: Please distribute this form to the person providing your professional reference. It is your responsibility to ensure that the form is collected and submitted along with your volunteer application.

Reference: Thank you for recommending this applicant. Please complete the form, enclose it in a secured envelope (placing your signature over the sealed flap), and return the confidential reference to the applicant for submission with his/her application. Thanks!

Volunteer Applicant's Name: _____

Reference Name (**print clearly**): _____ Title: _____

Organization: _____

Address: _____

City/State/Zip: _____ Phone: _____ Email: _____

Preferred Contact (for reference verification): Phone Email

Please circle the number in the scale that best reflects your assessment of the applicant.

How would you rank the applicant's...	LOW	AVERAGE			HIGH	Not observed
Quality of work?	1	2	3	4	5	
Dependability?	1	2	3	4	5	
Compassion for others?	1	2	3	4	5	
Judgment and problem-solving skills?	1	2	3	4	5	
Interpersonal communication with co-workers / peers?	1	2	3	4	5	
Interaction with clients / patients / customers / others?	1	2	3	4	5	
Leadership capabilities?	1	2	3	4	5	

1) How long have you known this applicant, and in what capacity?

2) The applicant may be providing direct patient services to a diverse, urban population. In order to ensure the highest possible quality of care, please indicate any reservations you may have about his/her ability to perform in this capacity.

3) What do you consider to be the applicant's character strengths, and how have they been demonstrated?

4) In what areas do you feel the applicant needs improvement?

5) Would you recommend this applicant for a volunteer position with our organization?

Please include additional comments on the back of this form, or attach a supplemental letter, if desired.

Reference's Signature: _____ Date: _____



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