



3319 J Street, Sacramento, CA 95816

VOUNTEER APPLICATION FOR HEALTH PROVIDERS

APPLICATION DATE: _____

Name: _____
(Last) (First)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth (month/day) _____ Email Address: _____

I am:

- Employed
- Un-employed
- Retired

I am:

Physician, Surgeon, Dentist, Mental Health professional, other _____

Medical Assistant, LVN, Nurse, Nurse Practitioner _____

School graduated: _____ Degree attained: _____ Year _____

State (s) or Country (ies) in which you are licensed to practice: _____

Specialty (ies) _____ Subspecialty: _____

Internship (PI): _____ Yr: _____ Residency (PI): _____ Year: _____

Are you in private practice? Yes ___ No ___ If yes, where? _____

How long? _____

Medical license#/certification #: _____ Expiration Date: _____

Medical practice insurance carrier: _____ Expiration Date: _____

Has your license been suspended in the past five years? Yes _____ No _____

Social Security Number _____ Drivers License Number _____

This information is used for background checks and to verify your identity. This information is held in strictest confidentiality and is not shared with anyone

Professional Employment/Work Experience: (List most recent employment first)

Place of employment	Hospital Affiliations	Start date	End date	Responsibilities

What Languages do you speak? _____

Special skills, and/or training _____

What interests you about volunteering at Clara's House?

Availability

Time available for volunteer occupation hours _____ per week

I would prefer: a regular schedule _____, a flexible schedule _____, on call as needed
schedule _____

Please let us know the best days and hours of the week for you:

Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
AM							
PM							

EMERGENCY NOTIFICATION

Name of Volunteer _____

Name of Party to be notified in emergency _____

Address _____

Telephone (day _____ (eve) _____)

Doctor's Name _____

Doctor's phone number _____

Hospital or HMO & Emergency # _____

REFERENCES

Name _____

Address _____

City/State _____

Email _____

Telephone (day) _____

Name _____

Address _____

City/State _____

Email _____

Telephone (day) _____

Please enclose copies of the following: 1) Current medical license 2) Diploma from medical school 3) Post graduate training certificate 4) Specialty board certificate if available. Mail application form to: 3319 J Street, Sacramento, California 95816. If you have any questions at all please feel free to call (916) 448-3976 or e-mail Clarashouse@clarashouse.org.

Thank you for your interest in volunteering at Clara's House!

PLEASE READ CAREFULLY AND SIGN

I certify that the information in this application is true. I understand that falsification of any information in this application, discovered at any time before, during, or after I begin my position as a volunteer at Clara’s House may lead to my termination.

I hereby authorize Clara’s House Volunteer Coordinator to verify, obtain copies of records and gather any information pertaining to my submitting a volunteer application with Clara’s House. My signature on this application authorizes Clara’s House Volunteer Coordinator to request written verification as needed.

The receipt of this application does not imply that I will be offered a position as a volunteer. If accepted as a volunteer, I agree to comply with established rules, policies and procedures. This includes, but is not limited to, those which relate to confidentiality, and universal precautions.

I understand my volunteer position with Clara’s House means volunteering at Clara’s House discretion; my volunteer position can be terminated at any time with or without cause, and with or without notice at the option of Clara’s House Volunteer Services myself.



Applicant’s Signature _____ **Date** _____

Return completed application form to Susan Boone, Volunteer Coordinator, 1211 – 24th Street, #A, Sacramento, CA 95816-5040

