



**AmeriCares Free Clinics, Inc.**

88 Hamilton Avenue

Stamford, CT 06902

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Email: freeclinics@AmeriCares.org

www.AmeriCaresFreeClinics.org

**VOLUNTEER APPLICATION ~ RN ♦ LPN ♦ EMT  
(All medical volunteers must be licensed in CT)**

Preferred clinic site(s):  Danbury  Norwalk  Bridgeport

Volunteer Interest:  RN  LPN  EMT  Other (please call) \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Education/Degree/Year: \_\_\_\_\_

License No. \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Yrs. of Experience: \_\_\_\_\_

Area(s) of special professional expertise/interest: \_\_\_\_\_

Other language:  Spanish  Portuguese  Other: \_\_\_\_\_

Language proficiency:  native speaker  fluent  conversational

**Most Recent Professional Employment and/or Volunteer History (or attach resume)**

Date started	Date Ended	Employer	Responsibilities

**Availability:** Please check all the days and times that you are available:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM					closed	
PM					closed	closed
Eve 4-7pm					closed	closed

**Commitment:** How often would you like to volunteer?

1 time per week  2 times per month  1 time per month  other \_\_\_\_\_

How did you hear about volunteering at AmeriCares Free Clinics (AFC)?

- Current volunteer       staff       AFC website       other website \_\_\_\_\_  
 Newspaper/magazine       TV/radio       other \_\_\_\_\_

Why do you want to volunteer and what do you hope to gain from volunteering at the AFC?

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Do you have any special skills or talents to contribute to AFC's efforts? (E.g. computer skills)

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Have you ever been named as a defendant in a malpractice case?

- Yes    No   If yes, please explain on separate sheet.

### REFERENCES

Please provide *both* a professional and personal reference. Please Note: The professional reference must address your clinical skills and clinical experience.

#### Professional Reference

Name: \_\_\_\_\_ Workplace: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Years known: \_\_\_\_\_

#### Personal Reference

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Years known: \_\_\_\_\_

I hereby affirm that the information provided in this application is true and completed to the best of my knowledge. I understand that providing false or misleading information may disqualify me from further consideration as a volunteer and may result in termination if discovered at a later date.

I understand that in my capacity as a volunteer with AmeriCares Free Clinics, I may come in contact with confidential information. I agree to protect this information to the best of my ability and not to divulge it during my volunteer experience or after my service has ended. I consent to the use of my photograph for any media as it pertains to the AmeriCares Free Clinics or AmeriCares.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_