



707 N. Ft. Harrison Ave. • Clearwater, FL 33755 • (727) 447-3041 • Fax: (727) 442-0320 www.ClearwaterFreeClinic.org

## Volunteer Application

### Applicant

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # \_\_\_\_\_  Home  Work  Cell

Phone # \_\_\_\_\_  Home  Work  Cell

How did you hear about the Clearwater Free Clinic?

\_\_\_\_\_

Personal Reference \_\_\_\_\_

Known How Long? \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Please provide a brief description of your past and/or present work experience and skills:

What type of volunteer work would you like to do at the Clinic?

Physician    Nurse Practitioner    Pharmacist    Nurse    Clerical    Special Projects

When are you available to start? \_\_\_\_\_

How often would you like to volunteer at the Clinic?

Once a week    Twice a month    Once a month    Special projects    As needed

When are you available to help?    Mornings (9am -1pm)    Afternoons (1-5pm)    Evenings (5-7pm)

Do you prefer:    a regular schedule    to be called as needed

Signature \_\_\_\_\_

Date \_\_\_\_\_

*We will use this application to evaluate how you can best fit into the operation of the Clinic. If you become a Clinic volunteer, we will keep this application on file to maintain your emergency contact information.*

### Emergency Contact

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # \_\_\_\_\_  Home  Work  Cell

Phone # \_\_\_\_\_  Home  Work  Cell

Relationship \_\_\_\_\_