# Hope Medical Clinic, Inc.

Volunteer Application

# Contact Information

|  |  |
| --- | --- |
| Name |  |
| Birthday (MM/DD) |  |
| Street Address |  |
| City, State, Zip |  |
| Primary Phone |  |
| E-Mail Address |  |

# Availability

### When would you like to start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Please circle day(s) and time-frame(s) you are available to volunteer**:

|  |
| --- |
| Monday Tuesday Wednesday Thursday Friday |
| morning / afternoon |

# Interests

### Tell us in which areas you are interested in volunteering.

|  |
| --- |
|  |

# Special Skills or Qualifications

### If applicable, please attach a copy of any certification/licensure associated with the volunteer position you are interested.

|  |
| --- |
|  |

# Previous Volunteer Experience

### Summarize any previous volunteer experience.

|  |
| --- |
|  |

# Person to Notify in Case of Emergency

|  |  |
| --- | --- |
| Name |  |
| Street Address |  |
| City, State, Zip |  |
| Primary Phone |  |
| Secondary Phone |  |
| E-Mail Address |  |

# Agreement and Signature

### By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

|  |  |
| --- | --- |
| Name (printed) |  |
| Signature |  |
| Date |  |

# Our Policy

### It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

### **Thank you for completing this application form and for your interest in volunteering with us.**