Helen M. Nickless
VOLUNTEER CLINIC

DENTAL PROFESSIONAL VOLUNTEER APPLICATION

LAST NAME	FIRST NAME	MIDDLE INT

DENTAL SPECIALTY	WOULD YOU PREFER TO BE CONTACTED BY:	☐ DDS ☐ RDH ☐ RDA ☐ CDA ☐ DA ☐ Business Office ☐ OTHER _____
	☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ PAGER ☐ E-MAIL	

ADDRESS STREET CITY STATE ZIP	DATE OF BIRTH

HOME PHONE	WORK PHONE	CELL PHONE
( )	( )	( )

PAGER	E-MAIL ADDRESS
( )	

ARE YOU AWARE OF ANY MEDICAL, PHYSICAL OR MENTAL HANDICAP THAT WOULD AFFECT YOUR ABILITY TO PERFORM PROFESSIONAL DUTIES? ☐ YES ☐ NO

EXPLAIN: _____

DO YOU HAVE TRAINING/EXPERIENCE IN ANY SPECIAL AREA? ☐ YES ☐ NO. IF YES, DESCRIBE BELOW.

DO YOU SPEAK A FOREIGN LANGUAGE? ☐ YES ☐ NO IF YES, WHICH ONES:

CURRENT WORK SITE

~~ARE YOU PRESENTLY CONNECTED WITH BAY REGIONAL MEDICAL CENTER OR OTHER McLAREN AFFILIATE?~~

☐ YES ☐ NO IF YES, EXPLAIN BELOW:

ARE YOU CURRENTLY ON STAFF AT BAY REGIONAL MEDICAL CENTER? ☐ YES ☐ NO

ARE YOU CURRENTLY ON STAFF AT A HOSPITAL OTHER THAN BAY REGIONAL MEDICAL CENTER? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE NAME OF HOSPITAL:

HAVE YOU EVER HAD YOUR LICENSE REVOKED OR SUSPENDED OR ARE YOU IN THE PROCESS OF HAVING YOUR LICENSE SUSPENDED OR REVOKED? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ON A SEPARATE PAPER.

OVER ⇨

PROFESSIONAL REFERENCES

NAME			PHONE NUMBER	
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP**
NAME			**PHONE NUMBER**	
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP**

EMERGENCY CONTACT

NAME			PHONE NUMBER	
ADDRESS	**STREET**	**CITY**	**STATE**	**ZIP**

ASSIGNMENT PREFERENCES

Would you like to be scheduled to work with a friend or group (i.e. Co-workers, Church group, etc)?
☐ **YES** ☐ **NO** **IF YES, PLEASE LIST PREFERENCES BELOW:**

SCHEDULING PREFERENCE

When would you prefer to volunteer your services?

☐ **Evenings** ☐ **Daytime**

For your protection and that of our patients
ALL VOLUNTEERS ARE REQUIRED TO HAVE A TB SKIN TEST
Or proof that they have had a test within the past year.

This test is available at Bay Regional Medical Center's (BRMC) Employee Health at no charge to volunteers.
For further information please call (989) 894-3158

LICENSED DENTAL PROFESSIONAL

If you are a licensed practitioner and not on staff at Bay Regional Medical Center or Bay Special Care Hospital, please submit copies of the following:

- ❑ **Professional licenses**
- ❑ **Current CPR card**
- ❑ **TB test results**

SIGNATURE BELOW IMPLIES PERMISSION TO CREDENTIAL

SIGNATURE	DATE
X	