

**VOLUNTEER APPLICATION**

LAST NAME		FIRST NAME		MIDDLE INT	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> RPh <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> MA <input type="checkbox"/> CNA <input type="checkbox"/> OTHER	
DO YOU PREFER A NICKNAME	WOULD YOU PREFER TO BE CONTACTED BY:			MARITAL STATUS		
	<input type="checkbox"/> WORK PHONE <input type="checkbox"/> HOME PHONE <input type="checkbox"/> CELL PHONE <input type="checkbox"/> EMAIL			<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		
ADDRESS	STREET	CITY	STATE	ZIP	DATE OF BIRTH	
HOME PHONE ( )		WORK PHONE ( )		CELL PHONE ( )		
PAGER ( )		E-MAIL ADDRESS				
HAVE YOU EVER BEEN A VOLUNTEER? <input type="checkbox"/> YES <input type="checkbox"/> NO						
WHEN? (APPROX)			WHERE?			
ARE YOU AWARE OF ANY MEDICAL, PHYSICAL OR MENTAL HANDICAP THAT WOULD AFFECT YOUR ABILITY TO PERFORM VOLUNTEER DUTIES? <input type="checkbox"/> YES <input type="checkbox"/> NO						
EXPLAIN: _____						
ARE YOU PRESENTLY EMPLOYED BY OR CONNECTED WITH BAY REGIONAL MEDICAL CENTER OR OTHER McLAREN AFFILIATE? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, EXPLAIN BELOW (Affiliate Name, ie, VNSM, MMMI)						
ARE YOU PREPARING FOR ANY SPECIAL CAREER? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, DESCRIBE BELOW.						
EDUCATION <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> COLLEGE <input type="checkbox"/> OTHER:						
ARE YOU PRESENTLY A STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE:						
DO YOU HAVE TRAINING/EXPERIENCE IN ANY SPECIAL AREA? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, DESCRIBE BELOW.						
PLEASE LIST ANY SPECIAL SKILLS OR ABILITIES YOU POSSESS <input type="checkbox"/> COMPUTER <input type="checkbox"/> FUNDRAISING <input type="checkbox"/> FILING <input type="checkbox"/> OTHER: _____						
DO YOU SPEAK A FOREIGN LANGUAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHICH ONES:						
COMMUNITY AFFILIATIONS _____						
ARE YOU CURRENTLY EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO				MAY WE CONTACT YOU AT WORK <input type="checkbox"/> YES <input type="checkbox"/> NO		
CURRENT EMPLOYER				DATES OF EMPLOYMENT		
PREVIOUS EMPLOYER				DATES OF EMPLOYMENT		



**OVER**

**REFERENCES (Other Than Relatives)**

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**

<u>CLINIC NIGHT - WEDNESDAYS</u>	<u>ALTERNATE SERVICE AREAS (Approximate time)</u>
<input type="checkbox"/> CLINICAL 5:00 pm - closing	<input type="checkbox"/> CHART REVIEW Thursdays 9:30 am – 11:30 am
<input type="checkbox"/> PHARMACY 6:00 pm - closing	<input type="checkbox"/> OFFICE WORK Variable times
<input type="checkbox"/> INTAKE (INTERVIEWS) 4:45 pm - 7:00 pm	<input type="checkbox"/> FUND RAISING Variable times
<input type="checkbox"/> FRONT OFFICE 4:30 pm - 8:30 pm	<input type="checkbox"/> EVENTS Variable times
<input type="checkbox"/> GREETER 4:30 pm - 7:00 pm	<input type="checkbox"/> OTHER AREAS OF INTEREST (LIST BELOW)
(Approximate Times)	_____
	_____

Would you like to be scheduled to work with a friend or group (i.e. Co-workers, Church group, etc)?

**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.**

**IF YOU ARE NOT A MCLAREN AFFILATE**

**HAVE YOU HAD A TB SKIN TEST IN THE PAST YEAR?  YES  NO**  
If yes, please submit proof along with this application.

**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**

**HAVE YOU HAD HIPAA TRAINING?  YES  NO**  
If yes, please submit proof along with this application.

**PRACTITIONERS ONLY**

**Please submit copies of your professional licenses, C.V., and diploma with this application if you are a licensed practitioner and not on staff at Bay Regional Medical Center or Bay Special Care Hospital**

**PHARMACISTS ONLY**

**Please submit copies of your Michigan license with this application if not on staff at Bay Regional Medical Center or Bay Special Care Hospital**

SIGNATURE	DATE
<b>X</b>	