Community Care Clinic
141 Health Center Drive Suite B, Boone, NC 28607
Phone: 828-265-8591 Fax: 828-268-9963
cccvolunteering@gmail.com

VOLUNTEER APPLICATION

Please note that a minimum time commitment of 3 months is required of all volunteers*

Personal Information:

Name: _____ Date: _____

Address: _____

_____

Residency: ❑ Full-Time Resident ❑ Part-Time Resident Time of Year in Area: _____

Contact Information:

Phone (H): _____ (C): _____ E-mail: _____

Preferred method of contact: ❑ Home ❑ Cell ❑ E-mail ❑ Any

Employment:

❑ Employed FT ❑ Employed PT ❑ Retired ❑ FT Student ❑ PT Student

Current/Most Recent Employer: _____

Position: _____

Education:

College/University: _____ Major: _____

Graduation Date: _____ For current students, what year?: _____

Please note that we do not sign off on hours for practicums, service learning, etc. Also, we do not make special accommodations to earn a specific amount of volunteer hours within a given time frame*

Licensed/Certified Professionals:

Please attach a photocopy of your current professional licensure.*

License type and number: _____ Expiration Date:_____

Have you worked in position in which you utilized your licensure/certification? ❑ Yes ❑ No

If yes, list experience: _____

Has your professional license ever been restricted in any way? ❑ Yes ❑ No
If yes, please attach documentation.*

Background Check:

Would you be willing to have a background check? ❑ Yes ❑ No

Background information:

How did you find out about the Community Care Clinic?

Why are you interested in volunteering at the Community Care Clinic?

Do you have any prior volunteer experience? If so, where did you volunteer and for how long?

References:

Please provide the following contact information for two people who may provide information relative to your character and suitability for volunteer work at the Community Care Clinic. We will contact all references via e-mail or by phone.

(Name)	(E-Mail)	(Phone)	(Relationship)
(Name)	(E-Mail)	(Phone)	(Relationship)

Emergency Contact Information:

Name: _____

Phone Number(s): _____

Address: _____

Volunteer Position Desired (check all that apply):

Position requires appropriate professional training or certification.

Clinical Volunteers

❑ Medical Provider* (MD, DO, PA, NP)

❑ Medical Intake* (RN, LPN, CNA, EMT)

❑ Phlebotomist*

❑ Acupuncturist*

❑ Mental Health Counselor*

❑ Resource Volunteer

❑ Interpreter (Language :_____)

Administrative

❑ Receptionist

❑ Clerical (Phones/Computer)

❑ Special Projects

Committee Service

❑ Fundraising

❑ Publicity

❑ Board

Availability:

Our regular business hours are listed below however; there we may have special projects or events that occur outside these hours in which we may need volunteer support.

- **Main Clinic Hours:** Mon/Wed/Thurs: 9am-5pm Tues: 9am-8pm Wed: 9am-5pm Fri: 9am-3pm
- **Satellite Clinic Hours:** Cove Creek: Mon 10am-4pm Hospitality House: Wed 5-8pm

Please indicate which days and times you are available to volunteer (check all that apply):

Monday	❑ 9am-1pm	❑ 1-5pm	Other:_____	
Tuesday	❑ 9am-1pm	❑ 1-5pm	❑ 5-8pm	Other:_____
Wednesday	❑ 9am-1pm	❑ 1-5pm	❑ 5-8pm	Other:_____
Thursday	❑ 9am-1pm	❑ 1-5pm	Other:_____	
Friday	❑ 9am-1pm	❑ 1-5pm	Other:_____	

Frequency of service:

❑ 1X/Month ❑ 1X/Week ❑ 2X/Week ❑ Other_____

Time commitment:

Please note that a minimum time commitment of 3 months is required of all volunteers*

❑ 3 months ❑ 6 months ❑ 1-year ❑ More than 1 Year ❑ Other: _____

Additional Information about your volunteer availability:

(i.e. upcoming vacation, university breaks, exam weeks, fieldwork/internship, etc.)_____

_____

Signature: ____ **Date:** ________________