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 www.canyonclinic.org

VOLUNTEER FORM

(All medical volunteers must be licensed in Idaho **)

Volunteer Interest: Clinic Provider Clinic Nurse Screener General Office Other (please call)

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Education/Degree/Year: _____

**License No: _____ Expiration Date: _____ Yrs. of Experience: _____

Area(s) of special professional expertise/interest: _____

Other language: Spanish Other: _____

Language proficiency: native speaker fluent conversational

Most Recent Professional Employment and/or Volunteer History (or attach resume)

Date Started	Date Ended	Employer	Responsibilities

Availability: Please check all the days and times that you are available:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM						closed
PM						closed
Eve 4 - 7pm						closed

Commitment: How often would you like to volunteer?

1 time per week 2 times per month 1 time per month other _____

How did you hear about volunteering at Canyon County Community Clinic)

- Current volunteer staff Canyon Clinic website other website _____
 Newspaper TV/radio other _____

Why do you want to volunteer and what do you hope to gain from volunteering at Canyon Clinic?

Do you have any special skills or talents to contribute to Canyon Clinic's efforts? (E.g. computer skills)

Have you ever been named as a defendant in a malpractice case?

- Yes No If yes, please explain on separate sheet.

REFERENCES

Please provide *both* a professional and personal reference. Please Note: The professional reference must address your clinical skills and clinical experience.

Professional Reference

Name: _____ Workplace: _____ Title: _____
Phone: _____ Email: _____ Years known: _____

Personal Reference

Name: _____ Workplace: _____ Title: _____
Phone: _____ Email: _____ Years known: _____

I hereby affirm that the information provided in this application is true and completed to the best of my knowledge. I understand that providing false or misleading information may disqualify me from further consideration as a volunteer and may result in termination if discovered at a later date.

I understand that in my capacity as a volunteer with Canyon County Community Clinic, I may come in contact with confidential information. I agree to protect this information to the best of my ability and not to divulge it during my volunteer experience or after my service has ended. I consent to the use of my photograph for any media as it pertains to Canyon County Community Clinic.

Signed: _____ Date: _____