Mercy Medical Clinic

Volunteer Application

Name:_____ DOB:_____

Home Address:_____

_____

Home Phone:_____ Cell Phone:_____

Email:_____

In Case of Emergency, notify:_____

Phone:_____

Occupation:_____

Health (physical limitations)_____

_____

Education:_____

Hobbies:_____

Church:_____

Personal Reference #1:_____

Personal Reference #2:_____

When would you like to volunteer? (Please check)

Time: Mornings _____ Afternoons _____ Both _____

Days: Mon._____ Tues._____ Wed._____ Thurs._____ Fri._____ Sat._____

Licensure Info:

License #_____ Exp. Date:_____

License #_____ Exp. Date:_____

DEA #_____ Exp. Date:_____

Please provide a copy of licenses/certifications/CPR card.

To the best of my knowledge, the above information is true.

Signature_____ Date_____

To the best of my knowledge, my licensure is in good standing.

Signature_____ Date_____