Albrecht Free Clinic

VOLUNTEER MEDICAL APPLICATION

Today's Date: _____

VOLUNTEER:

Full Legal Name_____
(Last) (First) (Middle initial)

Former Names and Nicknames _____

Home Phone: _____Business Phone: _____Cell Phone:_____

Date of Birth: _____ Address:_____
(Street) (City) (Zip code)

E-mail address: _____ What is the best way to contact you? _____

Have you ever been a patient at the Albrecht Free Clinic? _____ (Y/N)

Are you available to be contacted last minute?_____ (Y/N) How best to contact you last minute?_____

PROFESSIONAL AND COMMUNITY EXPERIENCE:

Are you presently (mark all that apply): Employed ☐ Retired ☐

☐ Previous Volunteer Medical Experience _____

☐ Currently in Practice/Location _____

Professional Capacity _____

Other pertinent information _____

AREAS OF VOLUNTEER INTEREST:

Please let us know which area(s) you would like to volunteer in. You may check more than one:

Nursing (Please select your level)		*Provider*
CNA	RN	MD
EMT	LPN	NP
MA		PA
		DO

PROFESSIONAL LICENSE:
Please include any type of professional license(s) you may have obtained in your career field, and would like to utilize in your volunteer experience.

Type of license: _____ **Expiration Date:** _____

Skills (areas of expertise): _____

_____

_____

AVAILABILITY:
The Albrecht Free Clinic offers five clinic times throughout the week. Patient volumes may vary depending on whether the clinic is walk - in or by appointment. Monday, and Wednesday appointments are once a month. Tuesday appointments are twice a month.

Please indicate the days and time you are available to help:

☐ **Monday, Tuesday & Wednesdays**
8:45a.m. - 12:00p.m.
Appointments

☐ **Tuesdays & Thursdays**
5:30 pm. - 8:00 pm.
Appointments

REFERENCES: Please list two individuals (other than relatives) who can tell us about your professional and community experience(s). You may also submit letters of recommendation. The Albrecht Free Clinic reserves the right to request an alternate reference.

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

HEALTH:

Are there any accommodations we need to make to facilitate your participation? _____

_____

Are you free of communicable disease? _____

Rubella Test _____ TB Test _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone: _____

Background Check:

Have you ever been convicted of a felony or misdemeanor or have any charges pending against you? ☐ yes ☐ no

Have you ever paid a civil fine or forfeiture for a non - traffic related offense? ☐ yes ☐ no

If yes, please provide us with an explanation of the offense(s), and the date(s) in which it/they occurred. No applicant will be denied a volunteer position because of a conviction for an offense, a pending criminal charge, or payment of a civil forfeiture or fine which the Albrecht Free Clinic determined is not substantially related to the circumstances of the volunteer position sought. Please use a separate sheet of paper if necessary.

_____

_____

Note: The Albrecht Free Clinic reserves the right to complete full background checks.

I certify my answers to be true and complete.

Signature: _____ Date:_____

Once you have completed the application you may return the form in one of the following ways:

Mail or Drop off to: Albrecht Free Clinic
908 W. Washington St
West Bend, WI 53095

Fax: 262-306-7717

Email: contact@albrechtfreeclinic.org