



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)

CNA RN
EMT LPN
MA

Provider

MD
NP
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 _____

Have you received the COVID Vaccine? yes no

Please note that the Albrecht Free Clinic follows the guidance of local healthcare providers. Currently all volunteers should be vaccinated and masked to be inside the clinic.

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