



**THE FREE MEDICAL CLINIC of Greater Cleveland**

Office (216) 721-4010 \_ Fax (216) 721-2431 \_ [www.thefreeclinic.org](http://www.thefreeclinic.org)

***Volunteer Application Packet***

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Dear Prospective Volunteer:

Thank you for expressing an interest in volunteering at The Free Medical Clinic of Greater Cleveland. We take great pride in how successfully our organization is run, but we could not be as productive and effective as we are without the assistance from our amazing **VOLUNTEERS!**

Attached is our volunteer application. Your application will be complete when you have included the following items, to be submitted in one packet:

- \_\_\_\_\_ The two-sided application
- \_\_\_\_\_ Two completed reference forms (in separate sealed envelopes – see Reference Check Form for instructions)
- \_\_\_\_\_ Copies of current licenses and/or certificates (if required)

**PLEASE DO NOT SUBMIT YOUR APPLICATION UNTIL ALL COMPONENTS HAVE BEEN FULLY COMPLETED.** We cannot proceed with volunteer placement in our organization until all application materials have been received. Thanks for your cooperation!

Please direct completed applications to **The Free Clinic, Attn: Volunteer Coordinator, 12201 Euclid Avenue, Cleveland, OH 44106.** You may mail your application or drop it off at our front desk.

We are glad that you are considering volunteering your time at The Free Clinic – we assure you that your dedication is greatly appreciated by our staff and patients. You will surely gain an experience unparalleled while working alongside our remarkable staff and other volunteers in our beautiful facilities. We appreciate your interest and look forward to welcoming you to The Free Clinic team!

*\* Please keep this front page for your reference. \**



**THE FREE MEDICAL CLINIC of Greater Cleveland**

12201 Euclid Avenue ♦ Cleveland, Ohio 44106-4399 ♦ PHONE: (216) 721-4010 ♦ FAX: (216) 721-2431

**Volunteer Application ?**

Please PRINT clearly!

*When complete, return to The Free Clinic Volunteer Coordinator*

Name: Preferred Nickname: Date:

Home Phone: Cell: Business: E-Mail:

Preferred method of contact: Home Business E-mail Any

**CURRENT or MAILING ADDRESS**

Address: City/State: Zip:

Would you like to receive The Free Clinic quarterly newsletter (hard copy or email)? Yes No

**PERMANENT ADDRESS (if different)**

Address: City/State: Zip:

**EMPLOYMENT INFORMATION**

I am: Employed Un-employed Retired Student

Employer /School Occupation

Employer Address Department/Suite Number

City/State Zip Business Phone

**Professional Employment / Practice History**

Date Started	Date Ended	Position	Responsibilities

**EDUCATION**

(Check all that apply – please note degrees in progress)

H.S. diploma: School City/St. Yr

Undergrad degree: School City/St. Yr Major

Grad degree: School City/St. Yr Major

Educational Training / Licenses or Certifications (list all applicable degrees & credentials):

**\*\* PLEASE ATTACH A PHOTOCOPY OF YOUR CURRENT PROFESSIONAL LICENSES. \*\***

**FOR STATISTICAL PURPOSES ONLY – please complete**

I am age 18 or older **Birth day:**  
 Any languages other than English (including sign language)?

**Ethnicity:**

**Gender:**

**SERVICE OPPORTUNITIES**

What do you want to do? Order your interests by NUMBER (first choice = 1, second choice = 2, etc.). For job descriptions, requirements, & time commitments, see the Volunteer Information Book at our front desk or call the Volunteer Coordinator.

<p><b>MEDICAL CLINIC</b>          Patient Registration (History Taker)          Women's &amp; Teen Health Educator          Lab Tech / Phlebotomist          Pharmacy Technician          Registered Pharmacist          Well Physical Examiner (med students)          Practitioner / Physician          Resident          Certified Medical Clinic Assistant          Medical Clerical Support &amp; Projects          Medical Clinic Expediter / RN / LPN          Nutritionist / Dietician / Diet Tech          Other</p>	<p><b>MENTAL HEALTH CLINIC</b>          MH Intake Worker          MH Therapist          MH Psychiatrist          MH Psychiatry Resident          MH Student Intern          MH Clinical Supervisor          Other</p> <p><b>ADMINISTRATIVE</b>          Clerical / Typist / Data entry          Associate Board Member          Computer Administrator          Other</p>	<p><b>SUBSTANCE ABUSE TREATMENT CLINIC</b>          SAT Counselors          SAT Social Worker          SAT Case Manager          SAT Student Intern          SAT Group Facilitator          Other</p> <p><b>SPECIAL PROJECTS</b></p>
<p><b>HIV CLINIC</b>          HIV Intervention Specialist          Syringe Exchange Program Worker          Other</p>	<p><b>DENTAL CLINIC</b>          Dental Student (CWRU          3<sup>rd</sup> &amp; 4<sup>th</sup> yr only)          Dentist</p>	<p><b>COMMUNITY EDUCATION</b>          Youth Theater Project (ages 13-25)          HIV &amp; Health Education Outreach          (18 years and older)</p>

Have you volunteered at The Free Clinic before? If yes, when?

How did you hear about our needs at The Free Clinic?

Is there anything else you would like us to know about you (i.e., career goals, special needs, etc.)?

**How often would you like to volunteer?**

one time / specific project    1-2 times per month    1x / week    2x / week    more than 2x / week  
 How long of a commitment can you make as a volunteer?    3 months    6 months    9 months  
 more than 1 year

**PLEASE LIST THE TIMES YOU ARE AVAILABLE TO VOLUNTEER BELOW**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings							
Afternoons						clinic closed weekends	
Evenings							

**TWO references MUST be provided before you begin your service.**

\*Both Volunteer Professional Reference Check Forms must be attached **with** your application.

**FOR OFFICE USE ONLY**

App Rec: _____ Entered: _____ Refs: <u>  </u> <u>  </u> <u>  </u> Orient/Mtg: _____ Start Date/Active: _____
Comments:



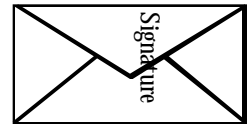
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**Volunteer Professional Reference Check Form**

Dear Sir or Madam:

Thank you for agreeing to be a reference for our volunteer. Please complete this entire form. Our volunteers must have at least two written references on file before they can provide service with our organization. Your reference check form must be returned to the potential volunteer, attn: Volunteer Coordinator, in a sealed (unopened) envelope with your signature written across the seal (see picture). Your cooperation and quick response (within 1 week upon receipt of this form) is greatly appreciated.



Potential Volunteer's Name: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Please check one column per question:**

<b>Questions</b>	<b>Unsatisfactory</b>	<b>Satisfactory</b>	<b>Excellent</b>
How would you rank this individual's quality of work?			
How would you rank this individual's dependability?			
What is/was this individual like to interact with as a co-worker, employee, associate or student?			
How is/was this individual's involvement with clients/patients/customers/others?			
How would you rank this individual's leadership capabilities?			

How long have you known this individual? \_\_\_\_\_

What is your relationship to this individual? \_\_\_\_\_

In order to ensure the highest possible quality of care for our patients, please briefly describe any areas of concern that we should know about regarding this individual. \_\_\_\_\_

Would you recommend this individual for a volunteer position with our organization? \_\_\_\_\_

Additional comments can be written on the back.

Reference's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



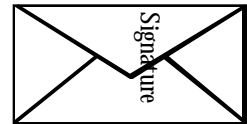
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Reference Name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Please check one column per question:**

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How is/was this individual's involvement with clients/patients/customers/others?			
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