

# St. Mary's Health Clinics Volunteer Application

1884 Randolph Avenue

St. Paul, MN 55105

## Personal Information:

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone (H) \_\_\_\_\_

Phone (W) \_\_\_\_\_

Phone (Cell) \_\_\_\_\_

E-mail \_\_\_\_\_

Referred by \_\_\_\_\_

Your Birthdate \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_ Year \_\_\_\_\_

## Preferred Clinic Site:

( ) Shakopee (Monday, 1-5:30PM)

( ) Shakopee (Wednesday 1:45-5:30PM)

( ) Shakopee, (Thursday 1:45-5:30PM)

( ) Park Avenue, Mpls. (Tuesday 1:45-5:30PM)

( ) Park Avenue, Mpls. (Thursday 1:45-5:30PM)

( ) St. Williams, Fridley (Tuesday 1:45-5:30PM)

( ) Eastside, St. Paul (Tues. 1:45-5:30PM)

( ) St. Matt's/Olivet, St. Paul (Mon.12:30-5:30PM)

( ) St. Matt's/Olivet, St. Paul (Wed.9AM- 12PM)

( ) St. Matthew's, St. Paul (Wed.1-5:30pm)

( ) St. Kate's, St. Paul, (Thursday 4:00-7:00)

( ) Outreach Consulate

## Preferred Volunteer Position:

( ) Physician ( ) NP ( ) Nurse ( ) Interpreter ( ) Driver ( ) Admitting ( ) Office Assistance ( ) OT ( ) PT

## Interests / Skills:

Language(s) other than English (indicate proficiency) \_\_\_\_\_

Work experience \_\_\_\_\_

Previous volunteer experience: \_\_\_\_\_

Education: \_\_\_\_\_

## Additional Information:

Person to contact in case of illness while on duty:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Any physical limitations we need to accommodate? \_\_\_\_\_

Have you ever been convicted of a felony? Yes or No

## M.D. / C.N.P / R.N. only

License / Certification Type (please circle) MD / CNP / RN / Other

Number \_\_\_\_\_ Exp. Date \_\_\_\_\_ Please attach copy of current license

DEA # \_\_\_\_\_

Have you had Hepatitis B Vaccination Yes / No

## References: (Professional for MD and Nurses - Personal for all other volunteers)

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

Phone: \_\_\_\_\_ Affiliation: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Affiliation: \_\_\_\_\_

Thank you for your interest in volunteering for Saint Mary's Health Clinics. We will review your application and contact you as soon as possible.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

