

VOLUNTEER APPLICATION

Please complete and return to the address or fax number to the right to the attention of Melissa Parker.

APPLICANT INFORMATION

Full Name:	Today's Date:
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Social Security Number:

Local Address:

City:	State:	Zip:
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E-mail:

Phone 1:	Phone 2:
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Permanent Address (if different than above):
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City:	State:	Zip:
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EMPLOYMENT INFORMATION

Employer Name & Address:

City:	State:	Zip:
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EDUCATION INFORMATION

High School:	Diploma:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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College:	Degree:
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OTHER INFORMATION

Emergency Contact 1:	Phone:
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Emergency Contact 2:	Phone:
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Volunteer Experience (organization, location, dates and duties):
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Is there any health issue that might limit your ability to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:

VOLUNTEER APPLICATION

How did you hear about our volunteer program? Newspaper Friend/Relative School Website Other

Are you 18 years of age or older? Yes No

INTERESTS/HOBBIES

Please describe your personal talents, hobbies, interests and special skills (i.e. crafts, musical instruments, software programs you are familiar with etc.):

REFERENCES

Please print names, addresses and telephone numbers of two people we may contact who have known you for more than one year (excluding relatives and roommates):

- 1.
- 2.

ACKNOWLEDGEMENT

I certify that all statements made in this application are true. I understand that United Family Medicine reserves the right to accept or reject my application at its sole discretion.

I understand that volunteers:

- > Are at least 16 years of age
- > Agree to have a background check before beginning to volunteer
- > Are required to interview with staff and attend volunteer orientation, and
- > Are required to sign a confidentiality agreement prior to beginning volunteer duties.

Signature: _____ Date: _____

OFFICE USE ONLY

Application Received: _____ Orientation/OSHA Training: _____

Background Check Clearance: _____ Notification of Placement: _____

Letter Sent: _____ Start Date: _____

Interview Scheduled: _____

DISCLOSURE – PREPARATION OF A CONSUMER REPORT

To process your application with United Family Medicine, an investigative consumer report (background check) may be conducted by Verified Credentials, Inc. In accordance with the U.S. Fair Credit reporting Act § 606, we notify you of the following: A background check report may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. Information may include, but is not limited to, employment history, education, criminal records, credit history, motor vehicle records, personal references, and any data provided on this application, or during the interview process.

Have you ever been convicted of a felony? Yes No
(A conviction will not necessarily be a bar to employment.)

If you answered “yes,” please describe the nature of the offense, the date of the convictions and the nature of any rehabilitation: _____

If currently employed, may your current employer be contacted? Yes No

I request a copy of this report. Yes No

Please read the following and, if acceptable, authorize us to order an investigative consumer report to be prepared by Verified Credentials, Inc.

AUTHORIZATION – TO PREPARE INVESTIGATIVE CONSUMER REPORT

I authorize the appropriate individuals, companies, institutions or agencies to release information requested for the preparation of an investigative consumer report on me and to respond to all inquiries necessary for the same.

Legal Last Name Legal First Name Legal Middle Name

Street Address

City State Zip Code

Please list any additional addresses you have lived, worked and attended schools in during the past 7 years :

City State City State

City State City State

Other Name(s) Used and Date(s) Changed: _____

Drivers License Number State Issued Expiration Date Date of Birth
(To be used for Background Information ID only)

I AUTHORIZE A PHOTOCOPY AND/OR AN ELECTRIC COPY OF THIS AUTHORIZATION TO BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL AND IF EMPLOYED BY THE ABOVE NAMED COMPANY THIS AUTHORIZATION WILL REMAIN IN EFFECT THROUGHOUT MY EMPLOYMENT.

Signature Social Security Number Date