OPEN ARMS FREE CLINIC
CLINICA GRATUITA

Volunteer Application

Applicant's name:		Date of Birth (MM/DD/YY):
Mailing Address:	City:	Zip:
Home Phone: ( )	Alternate (work/mobile): ( )	
Email:	Do you have a Facebook and/or LinkedIn profile: Y / N	
Emergency Contact:	Phone:	Relation:

Please check the areas that you are interested in volunteering for

MEDICAL

Do you have a current license in the state of Wisconsin for: (Check if applicable)

- ☐ Physician
- ☐ Nurse Practitioner
- ☐ Midwife
- ☐ Optometrist
- ☐ Physician Assistant
- ☐ Registered Nurse
- ☐ Dentist
- ☐ Podiatrist
- ☐ Pharmacist
- ☐ Practical Nurse
- ☐ Dental Hygienist
- ☐ Chiropractor
- ☐ Pharmacy Technician*
- ☐ Dietitian
- ☐ Physical Therapist

**Supervising Pharmacist WI Pharmacist Lic. #* _____

The health care professionals listed above will be enrolled in the Volunteer Health Care Provider Program (Wisconsin statute ch. 146.89) for additional liability coverage. If not listed above, do you carry private malpractice insurance? **Y / N**

NON-MEDICAL

- ☐ Clerical
- ☐ Data entry
- ☐ Receptionist
- ☐ Scheduling
- ☐ Intake screener
- ☐ Social Work
- ☐ Case Management
- ☐ Human Services
- ☐ Housekeeping
- ☐ Painting
- ☐ Maintenance
- ☐ Computer Systems
- ☐ Fundraising
- ☐ Hospitality
- ☐ Marketing
- ☐ Office / Clinic Management
- ☐ Other: _____

Do you speak/read Spanish? Yes ___ No ___ Additional Languages_____

Availability: Weekly_____ Twice monthly _____ Monthly_____ Other: _____

AUTHORIZATION & RELEASE I certify that the information I have provided is complete & accurate to the best of my knowledge. I release from any liability representatives of the Open Arms Free Clinic (CLINIC) for their acts in connection with evaluating my application, references and credentials. I understand that the position I am applying for is voluntary and for which there will be no monetary compensation. I authorize CLINIC and/or their agent to investigate my background including my professional, criminal and driving history and hereby release said information to them. I further release and discharge from liability CLINIC, their agents, employees, officers and other persons from all liability arising from the investigation or disclosure of the requested information, as well as those companies, agencies, officials, officers, employees and other persons, who in good faith provide this information to CLINIC and/or its agents. I will allow a photocopy of authorization to be as valid as the original.

Signature_____ Date_____

Complete and return to:
EMAIL: info@openarmsfreeclinic.org or
MAIL: Open Arms Free Clinic ATTN: Volunteer Coordinator; P.O. Box 560, Fontana, WI 53125