

- I am a homemaker and wish to feel a sense of accomplishment outside my home.
- I am retired and wish to continue to be an involved citizen.
- I am currently unemployed, but wish to increase my skills as a volunteer and/or obtain a reference for future employment opportunities.
- My place of employment takes volunteerism into consideration for career advancement.
- I am a student of _____ and I need this for _____.
- I am in my _____ year as a student at _____ College/University with a major in _____.
- Other _____

The following immunizations are recommended for all volunteers. Please indicate your status with each:

- Hepatitis B vaccine (series completed: ____ / ____ / ____)
- Tetanus toxoid (booster date: ____ / ____ / ____)
- TB test (date: ____ / ____ / ____)

I have reviewed the listing of Volunteer Opportunities. The one(s) in which I am interested and for which I believe myself to be qualified for are checked below:

- | | |
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| <input type="checkbox"/> Appointment Scheduler | <input type="checkbox"/> Office Helper |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Pharmacy Assistant |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Physician/NP/PA |
| <input type="checkbox"/> Eligibility Screener | <input type="checkbox"/> Receptionist |
| <input type="checkbox"/> Medical Screener | <input type="checkbox"/> Summer Teen Volunteer |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Other _____ |

Licensed Health Care Professionals- Specialty: _____	Virginia Board of: _____
License #: _____	Expiration Date: ____ / ____ / ____
DEA # (if applicable): _____	

I understand that all professional standards regarding medical confidentiality apply at the Lloyd F. Moss Free Clinic. This includes, but is not limited to, prohibition against copying medical records, removing medical records from the Clinic, and/or divulging information from the medical records to anyone else. All requests for such information should be referred to the Clinic staff.

Signature: _____ Date: _____

Staff Use Only: Application Received: ____ / ____ / ____ Initial Interview: ____ / ____ / ____ Orientation/Training Date: ____ / ____ / ____ Registered with DRM (if applicable): ____ / ____ / ____	Volunteer Works PIN Code: _____ Name Tag? <input type="checkbox"/>
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