

**Christ Clinic**  
Non-Profit Corporation  
914 W. Carlisle Ave., Spokane, WA 99205  
Phone: (509) 325-0393 Fax: (509) 325-7209

**APPLICATION FOR VOLUNTEER SERVICE**  
*FRONT OFFICE*

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address:

\_\_\_\_\_ Street City Zip

Home/ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell/ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address:

\_\_\_\_\_

Why do you want to volunteer at Christ Clinic?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Work Skills: (Please check those that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Typing        | <input type="checkbox"/> Wheelchair Assistance | <input type="checkbox"/> Telephone Skills                                       |
| <input type="checkbox"/> Filing        | <input type="checkbox"/> Blood Drawing         | <input type="checkbox"/> Obtaining Specimens                                    |
| <input type="checkbox"/> Transcription | <input type="checkbox"/> Use of Eye Charts     | <input type="checkbox"/> Vital Signs<br>(blood pressure, pulse, height, weight) |
| <input type="checkbox"/> Computer      | <input type="checkbox"/> Lab Procedures        |   |

Other Skills:

\_\_\_\_\_

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References:

1:

Name	Relationship	Phone
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2:

Name	Relationship	Phone
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Education:

High School: \_\_\_\_\_ City: \_\_\_\_\_

College: \_\_\_\_\_ City: \_\_\_\_\_

Other: \_\_\_\_\_ City: \_\_\_\_\_

Other: \_\_\_\_\_ City: \_\_\_\_\_

Volunteer Experience:

1: Organization name & Dates

volunteered: \_\_\_\_\_

Duties: \_\_\_\_\_

2: Organization name & Dates

volunteered: \_\_\_\_\_

Duties: \_\_\_\_\_

3: Organization name & Dates

volunteered: \_\_\_\_\_

Duties: \_\_\_\_\_

Employment: (Please list your most current employment and only those jobs which apply to this position)

1: Company name & Dates

employed: \_\_\_\_\_

Duties: \_\_\_\_\_

2: Company name & Dates

employed: \_\_\_\_\_

Duties: \_\_\_\_\_

3: Company name & Dates

employed: \_\_\_\_\_

Duties: \_\_\_\_\_

Availability:

Days able to volunteer: (please circle those which apply)

M T W TH F

Hours able to volunteer: \_\_\_\_\_ - \_\_\_\_\_ am / \_\_\_\_\_ - \_\_\_\_\_ pm

When are you able to start? \_\_\_\_\_

Can you commit to a year of service, volunteering 2 hour, 4 hour or longer shifts per month? \_\_\_\_\_

Do you have any mental, physical or sensory limitations that should be taken into consideration at the time of volunteer placement? \_\_\_\_\_ If yes, please explain:

\_\_\_\_\_

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Christ Clinic has my authorization to make inquiries into my past record of attendance, attitude, cooperation, dependability, interpersonal relations and learning ability.

I understand that all information which I may hear directly or indirectly concerning a patient, practitioner or any personnel will be considered **STRICTLY CONFIDENTIAL**, and I will not seek information in regard to any patient.

Misstatements or significant omissions of facts in this application may be grounds for discharge from this volunteer service. I understand that any offer of placement is contingent upon completion of health requirements: i.e. rubella screen, tuberculin test or others as needed.

I have read, understand and agree to the above.

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_