Community Care Clinic
141 Health Center Drive Suite B - Boone, NC 28607
Phone: 828-265-8591 Fax: 828-268-9963
cccvolunteering@gmail.com

VOLUNTEER APPLICATION

Please note that a minimum time commitment of 3 months is required of all volunteers*

Date: _____

Personal Information:

Name: _____

Address: _____

_____

Residency: ☐ Full-Time Resident ☐ Part-Time Resident Time of Year in Area: _____

Contact Information: E-mail: _____

Phone (H): _____ (C): _____

Emergency Contact Information:

Name: _____ Phone # _____

Address: _____

Employment: ☐ Employed FT ☐ Employed PT ☐ Retired ☐ FT Student ☐ PT Student

Current/Most Recent Employer: _____

Education:

College/University: _____

Major: _____ Graduation Date: _____

Licensed/Certified Professionals - ***Please attach a copy of license and/or certification*

License Type and number: _____ Expiration Date: _____

Have you worked in position in which you utilized your licensure/certification? _____

If yes, list experience (where & dates): _____

_____

Misc. information:

How did you find out about the Community Care Clinic? _____

Do you have any prior volunteer experience? If so, where did you volunteer and for how long?

_____

_____

Volunteer Position Desired (check all that apply): ***Position requires appropriate professional training or certification.***

Clinical Volunteers	**Administrative**	**Other:** ☐ Fundraising
☐ Medical Provider* (MD, DO, PA, NP)	☐ Clerical/Office Assistant	☐ Publicity
☐ Medical Intake* (RN, LPN, CNA, EMT)	☐ Data Entry/Scanning	☐ Board
☐ Phlebotomist*	☐ Special Projects	
☐ Mental Health Counselor*	☐ Resource Volunteer	

Availability:

Our regular business hours are listed below however; there we may have special projects or events that occur outside these hours in which we may need volunteer support.

Clinic Hours: **Monday – Thursday 8:45am – 5pm/*Tuesday evening hours: 5pm – 8:30pm *Friday 8:45am – 12pm*

***Please indicate which days and times you are available to volunteer (check all that apply):**

Monday	☐ 8:45am-12:30pm	☐ 1-5pm	☐ Other: _____
Tuesday	☐ 8:45am-12:30pm	☐ 1-5pm	☐ Other: _____
Wednesday	☐ 8:45am-12:30pm	☐ 1-5pm	☐ Other: _____
Thursday	☐ 8:45am-12:30pm	☐ 1-5pm	☐ Other: _____
Friday	☐ 8:45am-12:00pm	*Clinic closes at 12:00pm	

Frequency of service:

☐ 1X/Month ☐ 1X/Week ☐ 2X/Week ☐ Other_____

Time commitment: *****Please note that a minimum time commitment of 3 months is required of all volunteers*****

☐ 3 months ☐ 6 months ☐ 1-year ☐ More than 1 Year ☐ other: _____

Licensed/Certified Professionals: *****Please attach a photocopy of your current professional licensure. *****

License type and number: _____ Expiration Date: _____

Have you worked in position in which you utilized your licensure/certification? ☐ Yes ☐ No

Has your professional license ever been restricted in any way? ☐ Yes ☐ No
*****If yes, please attach documentation. *****

References:

Please provide the following contact information for two people who may provide information relative to your character and suitability for volunteer work at the Community Care Clinic. We will contact all references via e-mail or by phone.

Name: _____ Relationship: _____

Phone: _____ Email: _____

Name: _____ Relationship: _____

Phone: _____ Email: _____