



*Open doors.
Quality care.*

Send completed application to:

*Sarah Jane Cauzillo, Operations Assistant
1211 Lafayette Ave NE Grand Rapids MI, 49505
or sjcauzillo@catherineshc.org (616.336.8800 ext. 204)*

Volunteer Application

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Other Phone: _____
Email: _____
Contact Preference: Email Phone

Educational Background

School: _____ Dates Attended: _____ Major course of study/Degree: _____
1. _____
2. _____
3. _____

Are you a current student? Yes No

If yes, will you receive credit for your volunteer hours? _____

Employment/Volunteer Background

Dates:	Organization:	Type of Work:	Paid:	Volunteer:
1. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Current Professional Registration/License: _____

Have you ever been convicted of a felony? Yes No

If yes, please explain.

Please list all medical information we should know about (allergies, special medications, instructions, and/or conditions:

What type of work would you like to perform at CHC? Please check all that apply.

- | | | | |
|---|--|---------------------------------|--|
| <input type="checkbox"/> Clerical | <input type="checkbox"/> Medical Records | <input type="checkbox"/> R.N. | <input type="checkbox"/> Fundraising/Development |
| <input type="checkbox"/> Administrative | <input type="checkbox"/> Computer/Data Entry | <input type="checkbox"/> L.P.N. | <input type="checkbox"/> Women's Health Advocate |
| <input type="checkbox"/> Receptionist | <input type="checkbox"/> Medication Assistance | <input type="checkbox"/> M.A. | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Mailings | <input type="checkbox"/> Community Programs | <input type="checkbox"/> Events | <input type="checkbox"/> Maintenance |
| <input type="checkbox"/> Marketing/P.R. | | | |
| <input type="checkbox"/> Other: | | | |
-

What skills, training, or knowledge do you hope to utilize at CHC?

Are you bilingual?

Yes

No

If yes, which language(s):

Why do you want to volunteer at Catherine's Health Center?

How did you hear about Catherine's Health Center?

References

Name:

Phone:

Relationship:

1.

2.

Volunteer Availability

Time: _____ Day(s): _____

How often per week/month: _____

When are you available to start? _____

How long can you commit to this service? *(Note: we ask for a 6 month minimum commitment)* _____

At Catherine’s Health Center, it is our mission to provide high quality, affordable, and compassionate health care to the underserved in our community.

As a volunteer at CHC, I understand I will be required to follow all policies and procedures. I have completed this volunteer application and hereby declare the information provided to be accurate and complete to the best of my knowledge.

Applicant Signature Date