



.....FOR OFFICE USE ONLY

Date Received _____ Information Updates _____ Volunteer Type: _____
 Orientation Date: _____ Volunteer Contact List: _____ Background Ck: _____
 Start / Shadow Date: _____ Email / Distribution Lists: _____ Processed By: _____
 Database: _____

For Practitioners: Date Reviewed: _____ Approved: Y / N _____ Medical Director _____

Notes: _____

VOLUNTEER APPLICATION

We consider applicants for all volunteer positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

PERSONAL INFORMATION

Date: ____ / ____ / ____

Name: _____

Birthdate (mm/dd/yyyy): ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone: (____) _____

Home Phone: (____) _____ Cell Phone: (____) _____

E mail Address: _____ FAX : _____

VOLUNTEER SERVICES

Please mark "X" in the area in which you are licensed (1-8) or have an interest (9-12):

- | | |
|---|--|
| 1. ____ Physician (MD, DO) | 9. ____ Lab Technician / Phlebotomist |
| 2. ____ Family Nurse Practitioner (FNP) | 10. ____ Registered Dietitian |
| 3. ____ Physician Assistant (PA) | 11. ____ Spanish Interpreter |
| 4. ____ Nurse (RN, LVN) | 12. ____ Patient Registration / Office |
| 5. ____ Pharmacist (RPh) | 13. ____ Daytime Projects (clerical) |
| 6. ____ Pharmacy Technician | 14. ____ Dentist |
| 7. ____ Dental Hygienist | 15. ____ Student (school) _____ |
| 8. ____ Dental Assistant | 16. ____ Other _____ |

Health Care Professionals (1-8) must be licensed and/or certified in the state of Texas to practice at the Clinic. Please provide the following information:

License # / Certification: _____

CPR certification _____ Date of Expiration _____

SCHEDULE PREFERENCES

Preferred clinic night: Tuesday ____ Thursday ____
How often? 1x Month ____ 2x Month ____ 1 x every other month ____
Other: _____

LANGUAGE SKILLS

Do you speak fluent Spanish? Yes ____ No ____ Some ____

Please indicate other language(s) in which you are fluent (F) or can communicate (C):
Chinese ____ Portuguese ____ Japanese ____ Vietnamese ____ Other ____

VOLUNTEER EXPERIENCE / GOALS

Have you volunteered elsewhere? If so, where?

What are reason(s) for wanting to volunteer at Mercy Clinic?

What do you hope to achieve from your volunteer experience?

How did you hear about us?

REFERENCES

1. Name: _____

Phone: _____ Email _____

2. Name: _____

Phone: _____ Email _____

CONVICTION RECORD STATEMENT

Have you ever been convicted of, or received deferred adjudication for, a crime?

Yes ____ No ____

If yes, please explain:

AGREEMENT

I (print full name) _____ authorize any inquiry to be made on any information contained in this application if I am considered for volunteer placement which will include a background check. I understand that all files and records maintained by the Mercy Clinic are privileged and confidential. Any and all information that I may have access to may not be released or communicated to others unless authorized by the Executive Director or staff member who has also been authorized by the Executive Director to make that determination. I understand that I will be expected to treat all patients, volunteers and staff with respect. I understand and consent that any photos or video taken of me while at the Clinic can be used for Clinic purposes. I also understand that I am expected to honor my commitment to Mercy Clinic and if unable to, will find a replacement and notify the appropriate staff of my replacement. I acknowledge my understanding of the conditions of my voluntary service for the Mercy Clinic and acknowledge and understand that I must conform to the rules and regulations of the Mercy Clinic to the best of my ability or my voluntary services may be terminated.

Signature: _____

Date: _____

Mercy Clinic
P.O. Box 11557
Fort Worth, Texas 76110
peggyleitch@mercy-clinic.org
www.mercy-clinic.org
817.840.3501

Mercy Clinic
775 West Bowie Street
Fort Worth, Texas 76110
(physical address)



Background Check Authorization

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ DOB: _____

Telephone Number: _____

Drivers License Number/State: _____

The information contained in this application is correct to the best of my knowledge. I hereby authorize **Mercy Clinic of Fort Worth** and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number ; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to **Mercy Clinic of Fort Worth** or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

Mercy Clinic of Fort Worth and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____

(Required if applicant is a minor)