

**Good Neighbor Health Clinic and Red Logan Dental Clinic
70 North Main Street, White River Junction, VT 05001
(802) 295-1868 good.neighbor@hitchcock.org**

Community Volunteer Application

Name: _____
(first) (middle initial) (last)

Address: _____
(Street address or post office box)

(Town, State, Zip)

Contact information: Complete all and check the best way to contact you.

_____ **E-mail:** _____

_____ **Home phone:** (_____) - _____

_____ **Cell phone:** (_____) - _____

_____ _____ **work;** _____ **pager** _____ **fax**

Emergency Contact. Name: _____
Relationship: _____ **Phone(s):** _____

What are the best days of the week and times of day for you to volunteer?

How did you become interested in becoming a volunteer at the clinic?

What type of volunteer work would you like to do at the clinic?

Please list any other volunteer or employment experiences that may be related to work at the clinic:

If you are a student, please give your age _____, **expected year of graduation** _____, **and name of school** _____.

Page 2, Community Volunteer Application

References: We request that you provide two personal references (no family members please).

Name: _____ **Daytime Phone:** _____
Address _____
Relationship to you: _____

Name: _____ **Daytime Phone:** _____
Address _____
Relationship to you: _____

In being considered for a volunteer position at the Good Neighbor Health Clinic and Red Logan Dental Clinic, I agree that the clinic staff and any of the references provided may exchange information regarding my qualifications without incurring any liability. **If accepted as a volunteer at GNHC**, I agree that I am making a commitment to serve and agree that I will:

___ Demonstrate behaviors while interacting with others which include:
 Serve/help the patients, families, visitors, and co-workers
 Respect each individual's dignity and privacy

___ Call the clinic with as much advance notice as possible if I am unable to be work on my scheduled day;

FURTHERMORE AND WITHOUT EXCEPTION, I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors, or personnel and I will not seek to obtain information from a patient.

Signature: _____ **Date:** _____

Thank you for your interest in volunteering. Please return the completed application to the Good Neighbor Health Clinic at the mailing address on the front of this form.