

**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**

**Medical & Dental Volunteer Application (FTCA)**

**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**

**Clinicians: What professional services do you propose to provide?**

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

**What is your license number? VT \_\_\_\_\_ exp date \_\_\_\_\_**

**NH \_\_\_\_\_ exp date \_\_\_\_\_**

**Please attach a copy of your license to this application.**

**What is your DEA registration number? \_\_\_\_\_**

**Please attach a copy of your Drug Enforcement Administration (DEA) Control Substance Registration Certificate.**

**Do you have Active Staff Privileges at a local hospital?**

**Hospital(s) \_\_\_\_\_ Department \_\_\_\_\_**

**Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_**

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**References: We request that you provide names of both a professional and personal reference.**

**Professional Reference (clinical supervision)**

**Name:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Relationship to you:** \_\_\_\_\_

**Personal Reference (no family members please)**

**Name:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Relationship to you:** \_\_\_\_\_

**Emergency Contact. Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone(s):** \_\_\_\_\_

**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 and required documents (copy of license and DEA certificate) to the Good Neighbor Health Clinic at the address on front of form.***