GOOD SAMARITAN HEALTH CLINIC OF PASCO, INC
5334 ASPEN STREET,
NEW PORT RICHEY, FL. 34652
727-848-7789
FAX# 727-848-7890

VOLUNTEER APPLICATION

DATE: _____

NAME: _____

ADDRESS: _____
(Include Street, City/State/Zipcode)

CELL PHONE: _____ HOME PHONE: _____

WORK PHONE: _____ EMAIL:_____

EMERGENCY CONTACT NAME & PHONE: _____

BIRTHDAY: _____

FLORIDA PROFESSIONAL
LICENSE # TYPE _____
(Physician Asst., Nursing, Pharmacist, Dental Asst., etc)

CURRENT
EMPLOYER: _____
Name of Business/Address/Phone

VOLUNTEER
EXPERIENCE: _____
Name/Address/Phone

LOCAL REFERENCE: _____
Name/Address/Phone

CHECK VOLUNTEER INTEREST(S):

Building Maintenance____ Clerical____ Data Entry____ Dental Assistant____
EMT/ Paramedic _____Housekeeping____ Medical Assistant____ Nursing____
Pharmacist____ Pharmacy Support____ Physician____

Other Clinical Field (please specify) _____

Other Special Skills: (Arts, Carpentry, Computers, etc) _____

Have you ever been convicted of a felony crime in Florida or any other State? ___ Yes ___ No

If yes, please explain _____

Do you currently use illegal drugs? _____ Yes _____ No

Have you ever been convicted of a crime against a child or senior citizen? ____ Yes ____ No

If yes, please explain: _____

Please indicate your preference of day of week to volunteer:

Licensed Volunteer

____ Tuesday	10-12 p.m._____	1-3 p.m. _____	4-6 p.m.___
____ Thursday	10-12 p.m. ____	1-3 p.m. _____	4-6 p.m.___

Clerical Volunteer

____ Monday	10-12 p.m._____	1-4 p.m. _____	
____ Tuesday	10-12 p.m._____	1-4 p.m. _____	3-6 p.m.___
____ Wednesday	10-12 p.m. ____	1-4 p.m. _____	4-7 p.m.___
____ Thursday	10-12 p.m. ____	1-4 p.m. _____	4-7 p.m.___

How did you hear about the Clinic? _____

I hereby verify that the information I have provided in this application above is true and correct. I authorize the Good Samaritan Health Clinic to contact any references noted in this application.

_____ DATE: _____
Volunteer Signature

CONFIDENTIALITY AGREEMENT

I _____ (print name) agree that all patient, volunteer and Clinic information that I gain knowledge of, by virtue of volunteering at The Good Samaritan Health Clinic, whether of a clinical nature, or otherwise, will be held in the strictest of confidence. I will uphold the confidentiality of all patient information both during my tenure as a volunteer at the Good Samaritan Health Clinic, and after I terminate said volunteering. I understand that any breach in this confidentiality is subject to prosecution under State Law.

Date: _____ **_____**
Print Name

_____ **_____**
Witness **Signature**