211 Rock Springs Road
Milner, Georgia 30257
Phone: 678-688-1950
Fax: 770-227-7676

Volunteer Application
Medical Personnel

Name_____ ___ Dr. ___ Mr. ___Ms. ___Date _____

Mailing Address: _____

_____

Phone (Home) _____ (Cell)_____

E-Mail_____

DOB_____Church or Congregation (if applicable)_____

Title: ___Physician ___PA ___NP ___ RN ___LPN ___Pharmacist ___CNA

___Other _____

Status: ___Retired ___Actively Practicing Speciality: _____

License Number:_____Active/Inactive Expiration: _____

DEA Number _____

You must provide a copy of your current license

VOLUNTEER SERVIVCE AVAILABILITY:

(Initial hours will be Thursdays 4:30 – 7:30 pm one to two days per month)

I can serve one 3 hour shift: ____per week ___every other week ___per month ___every other month

Days preferred:_____

Please list references:

Professional:

1._____ phone_____

2._____ phone_____

Personal:

1._____ phone_____

2._____ phone_____

Are you completing these volunteer hours for school or other community requirement? ___Yes ___No
If so, please complete the following:

School: _____

Area of Study:_____

Requirements of volunteer experience (necessary hours, duties, etc.):_____

_____

_____

Supervisor's name, title and phone number_____

_____

Please attach necessary paperwork

EMERGENCY CONTACT INFORMATION:

Name_____Relationship_____

Address_____

Phone Number_____

All information is accurate to the best of my knowledge

SIGNATURE OF VOLUNTEER_____

DATE_____