Please Contact: Sharon Fisher
Phone: (720) 458-6174
Fax: (720) 458-6177
sfisher@doctorscare.org

Volunteer Application

*Name*____ *Date*_________________

*Address*______________________________________ *Date of Birth*________________________

City ________________________________ *State*_________ *Zip* ___________________________

*Home Phone*_________________________ *Cell Phone* ___________________________________

*Email*________________________________

Language Spoken *English*__________ *Spanish*________ *Other*__________
Language Written *English*__________ *Spanish*________ *Other*__________

How would you prefer to receive communication from Doctors Care? ☐ *Phone* ☐ *Mail* ☐ *Email*

Emergency Contact:
*Name*____ *Phone* ___________________________

Relationship to you ____

Employment & Education: *(If retired, list your last employer and year retired.)*

*Name of Company/Contact Person*____

*Phone*__________________________________ *Email*___________________________________

*Responsibilities*____

____

Name of School ____

Course of Study _________________________________*Graduation Date* __________________

Previous Volunteer Experience:
Name of Organization *Dates of Service*
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When Would You Prefer to Volunteer?

☐ *Monday* ☐ *Tuesday* ☐ *Wednesday* ☐ *Thursday* ☐ *Friday* ☐ *AM* ☐ *PM*

*Number of times per month*____

Please Check Areas of Interest:

☐ *Front Desk*
☐ *In-take Interviews (Interview Families for Eligibility)*
☐ *Data Entry*
☐ *Medical Records*
☐ *Renewals (Renew through mail)*
☐ *Special Projects*

Medical (Degree or Certification required, or students in their 3rd or 4th year excepted)
Other (please specify) ____

1. *How did you hear about Doctors Care?*

2. *What are your goals as a volunteer?*

3. *Is your commitment limited to a specific period of time (Short Term/Long Term)?*

4. *What do you believe are the valuable assets you will bring to Doctors Care?*

5. *What do you want to gain from this volunteer experience?*

6. *Please list any special skills or professional experience you would like to incorporate at Doctors Care:*

I understand that all client information is confidential and that I will NOT discuss client information with anyone outside the Doctors Care Office.

*Signature*____ *Date* ______________________