COAST COMMUNITY
HEALTH
center

1010 First Street SE, Suite 110, Bandon, Oregon 97411
Phone: 541-347-2529 Fax: 541-347-9196

Debra Guzman, FNP Dr. Hank Holmes, MD Laura Bye, FNP

Coast Community Health Center encourages the participation of volunteers who support our mission. If you are interested in volunteering, please complete this application and return it to COAST COMMUNITY HEALTH CENTER. Information contained on this form will be kept confidential and will help us find the most satisfying and appropriate volunteer opportunity for you. Thank you for your interest in our organization.

VOLUNTEER APPLICATION

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell phone:** _____

E-mail:_____

If employed, occupation / place of employment:

_____

Education:

_____

_____

How did you hear about Coast Community Health Center?

_____

_____

Is there a specific capacity in which you'd like to serve? What kind of work would you like to do with Coast Community Health Center?

_____

_____

_____

Have you had any past volunteer experience? If yes, please describe:

_____

_____

Please list any specific skills, talents or areas of interest that may be helpful to you in your work with Coast Community Health Center (certifications, experience ,etc.)

_____

_____

_____

How many hours a week can you commit to volunteering? _____

Are there specific days or times when you are **NOT** available?

_____

_____

Please list two references, at least one of them professional, if possible.

Name: _____

Phone: _____ **Cell phone:** _____

What is this person's personal and/or professional relationship to you? _____

Name: _____

Phone: _____ **Cell phone:** _____

What is this person's personal and/or professional relationship to you?_____

Why do you want to volunteer with Coast Community Health Center?

_____

_____

_____

Emergency Contact Information:

Name: _____**Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell phone:** _____

Name: _____**Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell phone:** _____

Do you have any physical limitations we should be aware of? If yes, please describe:

_____

_____

As a volunteer of our organization I agree to abide by the policies and procedures. I understand that I will be volunteering at my own risk and that the organization, its employees and affiliates, cannot assume any responsibility for any liability or any accident, injury, health problem with may arise from any volunteer work I perform for the organization. I agree that all the work I do is on a volunteer basis and I am not eligible to receive any monetary payment or reward for my volunteer services.

I acknowledge that I have been provided with, have read and agree to abide by the terms of the COAST COMMUNITY HEALTH CENTER Confidentiality Agreement.

COAST COMMUNITY HEALTH CENTER conducts background screening on employees and volunteers who are working with or have access to confidential and sensitive information. I acknowledge I have been provided with the Notice and Acknowledgement regarding background investigation. I am aware COAST COMMUNITY HEALTH CENTER will conduct a background check if my volunteer position involves working with sensitive patient information or confidential clinic information.

_____ _____

Volunteer Signature Date