

Volunteer Application for Licensed Healthcare Provider



Good Neighbor
Health Clinics

CONTACT INFORMATION

First	<input type="text"/>	MI	<input type="text"/>	Last	<input type="text"/>
Home Address	<input type="text"/>				
Employer	<input type="text"/>				
Work Address	<input type="text"/>				
Cell Ph	<input type="text"/>	Work Ph	<input type="text"/>		
Home Ph	<input type="text"/>	Email	<input type="text"/>		
SSN	<input type="text"/>	Date of Birth	<input type="text"/>		
<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other	<input type="checkbox"/> Decline		

Emergency Contact: In case of emergency, who would you like us to contact?

Name	<input type="text"/>		
Phone	<input type="text"/>	Relationship	<input type="text"/>

PROFESSIONAL INFORMATION

<input type="checkbox"/> MD	<input type="checkbox"/> PA	<input type="checkbox"/> DO	<input type="checkbox"/> APRN	<input type="checkbox"/> RN	<input type="checkbox"/> DDS	<input type="checkbox"/> DMD	<input type="checkbox"/> DH	<input type="text"/>
-----------------------------	-----------------------------	-----------------------------	-------------------------------	-----------------------------	------------------------------	------------------------------	-----------------------------	----------------------

License/Cert VT #	<input type="text"/>	Exp. Date	<input type="text"/>	
License/Cert NH#	<input type="text"/>	Exp. Date	<input type="text"/>	
if applicable	DEA #	<input type="text"/>	Exp. Date	<input type="text"/>
	NPI #	<input type="text"/>	Exp. Date	<input type="text"/>
	FEIN #	<input type="text"/>	Exp. Date	<input type="text"/>
	UPIN #	<input type="text"/>	Exp. Date	<input type="text"/>

Professional School	<input type="text"/>	Graduation Year	<input type="text"/>
Specialty (if any)	<input type="text"/>		

Please provide 2 professional references: (from organizations not associated with GNHC)

Name	<input type="text"/>		
City/St	<input type="text"/>	Relationship	<input type="text"/>
Email	<input type="text"/>	Daytime Phone	<input type="text"/>
Name	<input type="text"/>		
City/St	<input type="text"/>	Relationship	<input type="text"/>
Email	<input type="text"/>	Daytime Phone	<input type="text"/>

VOLUNTEERING WITH US

What professional services do you propose to provide?

When was your most recent clinical experience?

☐ currently OR date

How many clinics/month is the best match for you?

☐ once/month ☐ twice/month ☐ weekly other

What day and time is best for you?

1st choice

2nd choice

Part of our mission is to mentor aspiring health care professionals. Do you have experience working with medical students? What is your approach to mentoring?

Please provide the following documents:

- ___ Current Motor Vehicle Driver's License or other proof of identity
- ___ All active Professional License/s and Certificate/s
- ___ CV/Resume (or short biography including current professional status)
- ___ Current BLS Training Documentation
- ___ Immunization Records (including Covid-19)
- ___ Fitness for Duty Attestation (if retired)

As a volunteer applicant at Good Neighbor Health Clinics I agree: *(please initial)*

_____ Clinic representatives and any of my references may exchange information regarding my qualification and I authorize the release of information to verify my credentials.

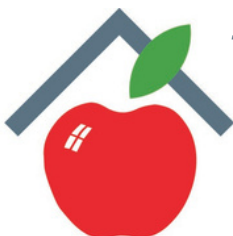
If accepted as a volunteer at GNHC, I agree that I am making a commitment to serve and agree that I will: *(please initial both)*

_____ Demonstrate behaviors while interacting with others, which include: Serving patients, families, visitors, and co-workers, respecting each individual's dignity and privacy, and maintaining the confidentiality of health information.

_____ Contact the clinic with as much advance notice as possible if I am unable to volunteer on my scheduled day.

I understand that failure to disclose full and truthful information on this application could result in denial of privileges.

Signature: _____ Date: _____



Thank you for your interest in providing vital health care to our neighbors!

Please return completed application and required documents:
email to Volunteers@GoodNHC.org

OR fax to 802-295-3600 (medical) OR fax to 802-359-1020 (dental)
OR mail to 70 North Main St, White River Junction VT 05001