Volunteer Application for Licensed Healthcare Provider

Good Neighbor Health Clinics

CONTACT INFORMATION

First | MI | Last

Home Address

Employer

Work Address

Cell Ph | Work Ph

Home Ph | Email

SSN | Date of Birth

☐ Female ☐ Male ☐ Other ☐ Decline

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

Name

Phone | Relationship

PROFESSIONAL INFORMATION

☐ MD ☐ PA ☐ DO ☐ APRN ☐ RN ☐ DDS ☐ DMD ☐ DH Other

License/Cert VT #		Exp. Date
License/Cert NH#		Exp. Date
if applicable DEA #		Exp. Date
NPI #		Exp. Date
FEIN #		Exp. Date
UPIN #		Exp. Date

Professional School | Graduation Year

Specialty (if any)

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

Name

City/St | Relationship

Email | Daytime Phone

Name

City/St | Relationship

Email | Daytime Phone

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