Mercy Clinic
of Fort Worth

.....FOR OFFICE USE ONLY .....

Date Received _____ Information Updates Volunteer Type: _____
Orientation Date: _____ Volunteer Contact List: ___ Background Ck: _____
Start / Shadow Date:_____ Email / Distribution Lists: ___ Processed By: _____
Database:

For Practitioners: *Date Reviewed:*_____ *Approved: Y / N* ___ *Medical Director*_____

Notes: _____

VOLUNTEER APPLICATION

We consider applicants for all volunteer positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status.

PERSONAL INFORMATION Date: ____ / ____ / _____

Name: _____
Birthdate (mm/dd/yyyy):___ / ___ / _____

Address:

_____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone: (____) _____

Home Phone: (____) _____Cell Phone: (____) _____

E mail Address: _____ FAX : _____

VOLUNTEER SERVICES

Please mark "X" in the area in which you are licensed (1-8) or have an interest (9-12):

1. ___ Physician (MD, DO)
2. ___ Family Nurse Practicioner (FNP)
3. ___ Physician Assistant (PA)
4. ___ Nurse (RN, LVN)
5. ___ Pharmacist (RPh)
6. ___ Pharmacy Technician
7. ___Dental Hygienist
8. ___Dental Assistant
9. ___ Lab Technician / Phlebotomist
10. ___ Registered Dietitian
11. ___ Spanish Interpreter / Interviewer
12. ___ Patient Registration / Office
13. ___ Daytime Projects (clerical)
14. ___ Dentist

Health Care Professionals (1-8) must be licensed and/or certified in the state of Texas to practice at the Clinic. Please provide the following information:

License # / Certification:

_____

CPR certication_____ Date of Expiration_____

For Practitioners: Do you have privileges at any local hospital(s)? Y/N: ____

If yes, which one(s)?

_____

SCHEDULE PREFERENCES

Preferred clinic night: Monday_____ Tuesday ____ Thursday ____ Sat AM____

How often? 1x Month _____ 2x Month _____ 1 x every other month ____

Other: _____

LANGUAGE SKILLS

Do you speak fluent Spanish? Yes _____ No _____ Some _____

Please indicate other language(s) in which you are fluent (F) or can communicate (C):
Chinese ___ Portuguese ___ Japanese ___ Vietnamese ___ Other ___

VOLUNTEER EXPERIENCE / GOALS

Have you volunteered elsewhere? If so, where?

_____

What are reason(s) for wanting to volunteer at Mercy Clinic?

_____

_____

What do you hope to achieve from your volunteer experience?

_____

_____

How did you hear about us?

_____

_____

REFERENCES

1. Name:_____
   Phone:_____ Email_____
2. Name:_____
   Phone:_____Email_____

CONVICTION RECORD STATEMENT

Have you ever been convicted of, or received deferred adjudication for, a crime?
Yes ___ No ___

If yes, please explain:

_____

_____

AGREEMENT

I (print full name) _____ authorize any inquiry to be made on any information contained in this application if I am considered for volunteer placement which will include a background check. I understand that all files and records maintained by the Mercy Clinic are privileged and confidential. Any and all information that I may have access to may not be released or communicated to others unless authorized by the Executive Director or staff member who has also been authorized by the Executive Director to make that determination. I understand that I will be expected to treat all patients, volunteers and staff with respect. I understand and consent that any photos or video taken of me while at the Clinic can be used for Clinic purposes. I also understand that *I am expected to honor my commitment to Mercy Clinic and if unable to, will find a replacement and notify the appropriate staff of my replacement.* I acknowledge my understanding of the conditions of my voluntary service for the Mercy Clinic and acknowledge and understand that I must conform to the rules and regulations of the Mercy Clinic to the best of my ability or my voluntary services may be terminated.

Signature: _____
Date: _____

Mercy Clinic
800 West Berry Street
Fort Worth, Texas 76110
mercyclinic@travis.org
817.840.3501

Mercy Clinic
of Fort Worth

Background Check Authorization

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

DOB:

Social Security Number: _____ _____

Telephone Number: _____

Drivers License Number/State: _____

The information contained in this application is correct to the best of my knowledge. I hereby authorize **Mercy Clinic of Fort Worth** and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number ; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to **Mercy Clinic of Fort Worth** or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

Mercy Clinic of Fort Worth and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____

(Required if applicant is a minor)