

NEW HOPE CLINIC, INC
VOLUNTEER APPLICATION

201 W. Boiling Spring Rd.
Southport, NC 28461
www.newhopeclinicfree.org

Phone: (910) 845-5333
Fax: (910) 845-5366
clinic@newhopeclinicfree.org

Name _____ (Preferred for name badge) _____

Email _____

Address _____

Mailing Address _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Preferred Method(s) of Contact: Email Home Work Cell

In Case of Emergency Please Notify _____

Relationship _____ Phone _____

Licensed in NC (Yes/No) _____ Type _____ License Number _____

How did you hear about New Hope Clinic? _____

Previous Experience: Career/Personal (Employer, title, dates, duties) _____

How would you like to help?

Front Office Administration (Reception)

Back Office Administration

Medical Records Clerk

IT Specialist

Interpreting: _____

Building & Grounds:

Landscaping

Repairs

Patient Eligibility

Marketing/Social Media

Design (newsletters/brochures)/Website

Community Outreach/Public Relations

Fundraising/Grant Writing

Volunteer Management

Practitioner: Primary Care or Specialties

Nursing (Licensed)

Unlicensed Assistive Personnel

(EMT, RN/LPN with inactive license, Medical Assistants)

Pharmacist

Pharmacy Technician

Dentist

Dental Assistant/Hygienist/Lab Tech

Patient Health Education

Other: _____

When would you like to volunteer? Morning

Afternoon

Evening

Special Events

Mondays

Tuesdays

Wednesdays

Thursdays

Fridays

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Please list two references:

Name _____ **Phone** _____
Relationship to volunteer _____

Name _____ **Phone** _____
Relationship to volunteer _____

***Please provide copy of Photo ID**

VOLUNTEER APPLICATION AGREEMENT

1. I certify that my answers on this application are true.
2. I authorize New Hope Clinic to verify the information submitted in this application and to contact the references provided.
3. If accepted as a volunteer at New Hope Clinic, I agree to abide by the rules and regulations of New Hope Clinic, Inc.
4. My services are donated without contemplation of compensation or future employment.
5. I shall not solicit any business for attorneys or insurance companies “for compensation”, both on or off Clinic property, or act as a runner for an attorney in the solicitation business. I shall report all known occurrences of solicitation for attorneys.
6. I shall not sell or attempt to sell goods or services, request contributions, or solicit persons to sign or distribute political petitions on Clinic premises.
7. I shall attempt to resolve any problems related to my volunteer activities with the New Hope Clinic Executive Director.
8. I understand that the Clinic reserves the right to terminate my volunteer status as a result of (a) failure to comply with Clinic policies, rules and regulations; (b) absences without prior notification; (c) unsatisfactory attitude, work, or appearance; or (d) any other circumstances which, in the judgment of the Executive Director, Medical Director, Dental Director, or Pharmacy Director, would make my continued service as a volunteer contrary to the best interests of the Clinic.

I have read each of the above conditions and I agree to be bound by them.

Volunteer Signature

Date

Volunteer Parent/Guardian Signature (If under age 18)

Date