Christian Care Center
Community Medical Care Center

Name: ____ Date: ____________________________

Home Phone:___________________________________ **Cell Phone:**_____________________________________

List all professional or occupational registrations, licenses or certifications that you have ever held.

	Current		Currently licensed in Florida		
	Yes	No	Yes	No	If yes, give license/certificate number

Positions Available: Please indicate first, second and third choices

________ **Receptionist** - greets, registers and checks out patients> Makes appointments, answers the phones, makes patient reminder calls , pulls and files medical records

________ **Interviewer** - talks with patients to determine eligibility, makes follow-up calls for missed appointments, makes referrals and helps patients utilize other community resources

________ **Nurse** - takes vitals and medical histories, assists practitioners and prepares treatment rooms

________ **Transcriptionist** - enters handwritten progress notes into computerized medical records system

________ **Statistical Clerk** - assists in the production of reports

Shifts Available: Please indicate times you are available.

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					
Evening					

Are there days and times that you cannot volunteer? ____

Please state how often that you would like to volunteer and any other information about your availability or interests that would aid us in creating a schedule and making assignments for you?

____

____

____

____

____

I understand and agree that all information as it relates to persons served by Community Medical Care Clinic of Leesburg, Inc. is to be held confidential. All information that comes to my attention and knowledge about patients will not be disclosed by me except to authorized personnel or with the written authority of the patient or his/her legal guardian. Disclosure of confidential information may result in my termination as a volunteer.

I agree to conduct myself in accordance with the policies of Community Medical Care Clinic of Leesburg, Inc. and affirm that all information on this application is true and complete.

____   ______________________________

Signature   Date