THE UNIVERSITY OF CHICAGO and the UNIVERSITY OF CHICAGO MEDICAL CENTER

Application to Volunteer at Free Clinics

This form is to be used by any UC or UCMC affiliated medical professional who intends to volunteer at a Free Clinic sponsored by the UC Medical Students or affiliated with the UCMC

NAME: ______________________________________________________________

Home Address: ____________________________________________________

Work Address:_______________________________________________________
Phone Number: ______________________ Email___________________________
(Indicate the best way for us to reach you)

Please check one:

____Physician
____Resident Physician
____Nurse
____Advanced Practice Nurse
____ Physician Assistant
____ Medical Student
____ Other (Describe)

Illinois License Number/Expiration Date
**Attach a copy of your current Illinois license, DEA license and certifications.**

(Our volunteers must have all of the training in infection control, HIPAA etc and have all of the immunizations and health and other screening required by UCH for privileges, training or employment.) How are you employed or credentialed at UCMC?
___________________________________________________________________________

Availability

In what area of practice can you volunteer at the Clinic?__________________

What days and hours can you volunteer at the Clinic?_________________

Would you be able to occasionally fill in for someone else at the Clinic?___________

Describe your goals as a Volunteer:

_________________________________________________________________________________________

_________________________________________________________________________________________

By signing this application, I request to be a volunteer at a Free Clinic. I understand that I will be expected to follow all applicable UCMC policies and procedures as well as any clinic procedures.

_________________________________________________________________________________________
Signature of Applicant Date