Waukesha Free Clinic
AT CARROLL UNIVERSITY

Formerly St. Joseph's Medical Clinic (SJMC)

Volunteer Application

Today's Date_____

Full Legal Name_____
(Last) (First) (Middle Initial)

Former Names and Nicknames_____

Home Phone _____ Business Phone _____ Cell Phone _____

Date of Birth_____

Address_____
(Street) (City) (Zip Code)

E-mail Address _____

Preferred method of contact: ☐Home ☐Business ☐Cell ☐Text ☐E-mail ☐Other_____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Have you ever been a patient at the Waukesha Free Clinic (WFC) or received services from WFC? ☐Yes ☐No

If yes, please explain _____

Are you related to a patient at SJMC or Waukesha Free Clinic (WFC)? ☐Yes ☐No

Have you ever been convicted of a criminal offense? ☐Yes ☐No

If yes, please provide an explanation of the offense(s) and the date(s) in which it/they occurred. Applicants will not be denied because of a conviction for an offense which is not substantially related to the circumstances of the volunteer position sought. Please use a separate sheet of paper if necessary. _____

_____

_____

Have you previously volunteered in a healthcare setting? ☐Yes ☐No

If yes, when? _____

How did you hear about Waukesha Free Clinic?_____

Are there any accommodations that we need to make to facilitate your participation? _____

_____

Areas of Volunteer Interests

Medical (Must be licensed):

☐ Physician ☐ Nurse Practitioner ☐ Psychiatrist ☐ Physician Assistant
☐ Counselor ☐ Registered Nurse ☐ Pharmacist ☐ Medical Assistant
☐ Chiropractor ☐ Physical Therapist

☐ Other Medical: _____

Non-Medical:

☐ Clerical ☐ Data Entry ☐ Receptionist ☐ Intake Screener ☐ Patient Advocacy
☐ Case Management ☐ Interpreter ☐ Fundraising ☐ Bookkeeping ☐ Marketing

☐ Other: _____

Do you speak/read Spanish? ☐ Yes ☐ No Additional Languages: _____

Availability:

Please let us know if you would prefer to help with:

☐ Clinic ☐ Non-Clinic ☐ Both ☐ Either (I am flexible.)

Please indicate the times and days you are available to help:

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					
Evening					

☐ Daily ☐ Weekly ☐ Monthly ☐ Every Other Month
☐ Other (please specify) _____

What length of commitment are you willing to make?

☐ Long-term ☐ One year ☐ Six months ☐ Semester ☐ Other: _____

Authorization and Release:

I certify that the information I have provided is complete and accurate to the best of my knowledge. I understand that:

- An agent of Waukesha Free Clinic will be checking my background with the appropriate public authorities.
- If I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in immediate dismissal.
- Completing the application process does not guarantee acceptance as a volunteer.

Signature: _____ Date: _____

Complete and return to:
Email: info@waukeshafreeclinic.org
Fax: 262-544-6667
By Mail at:
Waukesha Free Clinic
237 Wisconsin Ave. | Waukesha, WI 53186