



United Family Medicine

A COMMUNITY CLINIC

1026 West 7th Street
Saint Paul, MN 55102

651-241-1103 DIRECT
651-241-1138 FAX
unitedfamilymedicine.org

VOLUNTEER APPLICATION

Please complete and return to the address or fax number to the right to the attention of Tina Scheid.

APPLICANT INFORMATION

Full Name:		Today's Date:
Social Security Number:		
Local Address:		
City:	State:	Zip:
E-mail:		
Phone 1:	Phone 2:	
Permanent Address (if different from above):		
City:	State:	Zip:

EMPLOYMENT INFORMATION

Employer Name and Address:		
City:	State:	Zip:

EDUCATION INFORMATION

High School:	Diploma: <input type="checkbox"/> Yes <input type="checkbox"/> No
College:	Degree:

OTHER INFORMATION

Emergency Contact 1:	Phone:
Emergency Contact 2:	Phone:
Volunteer Experience (organization, location, dates and duties):	
Is there any health issue that might limit your ability to volunteer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
How did you hear about our volunteer program? (Please check one) <input type="checkbox"/> Newspaper <input type="checkbox"/> Friend / Relative <input type="checkbox"/> School <input type="checkbox"/> Website <input type="checkbox"/> Other	
Are you 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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INTERESTS / HOBBIES

Please describe your personal talents, hobbies, interests and special skills (i.e.; crafts, musical instruments, software programs you are familiar with etc.):

REFERENCES

Please print names, addresses and telephone numbers of two people we may contact who have known you for more than one year (excluding relatives and roommates):

- 1.
- 2.

ACKNOWLEDGEMENT

I certify that all statements made in this application are true. I understand that United Family Medicine reserves the right to accept or reject my application at its sole discretion.

I understand that volunteers:

- Are at least 16 years of age,
- Agree to have a background check before beginning to volunteer,
- Are required to interview with staff and attend volunteer orientation, and
- Are required to sign a confidentiality agreement prior to beginning volunteer duties.

Signature:

Date:

OFFICE USE ONLY

Application Received:

Orientation / OSHA Training:

Background Check Clearance:

Notification of Placement:

Letter Sent:

Start Date:

Interview Scheduled:



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PRE-VOLUNTEER INFORMATION RELEASE *(must be fully completed and signed)*

AUTHORITY AND CONSENT TO RELEASE/OBTAIN BACKGROUND INFORMATION

The information received by the Department of Human Resources Management as a result of signing this Release may be used to assist in a background investigation of you and may be used in conjunction with your application to evaluate your suitability for volunteering at United Family Medicine.

I hereby authorize the release to United Family Medicine of information held by any parties regarding previous employment, my criminal history record, and or record of convictions in state and local files for violation of any federal, state, local statutes or ordinances, military records, my credit history, worker's compensation history, driving record, and scholastic/educational records and hereby release said persons, schools, companies, government agencies, court and law enforcement authorities from damage whatsoever for reusing this information.

I hereby acknowledge that United Family Medicine cannot vouch for or guarantee the accuracy of information provided by third parties. Accordingly, I release United Family Medicine and its agents from any and all liability arising out of any errors or omissions regarding my background information. Any information obtained by United Family Medicine independently or through a Consumer Reporting Agency shall remain confidential and no further disclosure to other parties shall result. The information obtained as a result of the investigation shall be used exclusively for the purpose of volunteering.

Any misrepresentation, falsification or misleading statements or omission of facts by me may result in my being disqualified from further consideration for volunteering at United Family Medicine.

This permission is given this _____ day of _____, _____.

(Day) (Month) (Year)

APPLICANT INFORMATION

Full Name:		
Street Address:		
City:	State:	Zip:
Social Security Number:	Date of Birth*:	Ethnicity*:
Driver's License Number:	State:	
Signature:	Date:	

* Age and Ethnicity are not a criterion in any decision. They are used for identification purposes only.