85 HOPE Medical Clinic
Volunteer Application

Name:____Today's Date:___________________

Address:____ Date of Birth:_______________

Cell phone:____________________________ Other phone:____________________________

Email address: ____

Preferred way(s) to be contacted: Call Email Text

Our Mission: 85 HOPE is a free medical clinic inspired by the Gospel of Jesus Christ to provide primary healthcare to uninsured and under-insured, low-income adult residents of Wabash County.

- ☐ I have read and understood 85 HOPE's Mission Statement.
- ☐ I affirm that I am 18 years of age or older.

<u>Professional Licensing/Work Experience/Education</u>

Would you like to work in a medical or non-medical capacity?___________________________

What professional education, degrees, certifications, or licensures do you have that may be useful at the clinic?

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____

If professionally licensed, is your license currently active in the state of Indiana? Yes No

<u>(Please include a copy of all licensures and certifications.)</u>

Has your professional license ever been suspended or sanctioned? Yes No
If yes, please explain:____

Current employer (if applicable):____

Current/former work experience:____

Other special abilities or experiences you would think would be helpful at 85 HOPE?

____

____

Work Preferences:

Role preferences (please mark all that apply):

Non-Medical: ____Clerical/Office Assistant ____Cleaning
____Waiting Room Reception ____Other:____________________________

Medical: _____Provider _____Provider Assistant _____Triage
_____Intakes _____Pharmacy _____Other:______________________

Preferred clinic site: _____Wabash _____Manchester _____Either

Preferred time(s)/location(s) to work (please mark all that apply):

Wabash site:

- Office days (prep for clinic, intakes, office work, cleaning, etc.):
  - _____Tuesdays 1-5pm _____Thursdays 1-4 pm

- Clinic evenings:
  - _____Thursdays: 4:30-8pm

Manchester site:

- Office days: (prep for clinic, intakes, office work, cleaning, etc.)
  - _____Tuesdays 3-5 pm
- Clinic evenings:
  - _____1st Tuesday 4:30-8 pm _____3rd Tuesday 4:30-8 pm

References: Please provide two character or work-related references.

1. Name____

Cell phone or Email address____

Title/Relationship____

2. Name____

Cell phone or Email address____

Title/Relationship____

By signing below, I state that the above information is true and accurate, to the best of my knowledge.

Signed:____ Date:_____________________________

Please mail completed application to
85 HOPE Medical Clinic, PO Box 27, Wabash, IN 46992
or scan/email to director@85hope.org or fax to 260-274-0033. Thank you.

Criminal History Release Form

I, __________________________ __________________________ _____________________________,
(print first name) (print middle name) (print last name)

hereby request the Wabash County Sheriff's Department to release any criminal information on file under the above name to 85 HOPE, PO Box 27, Wabash, IN 46992. I hereby release the Wabash County Sheriff's Department from all liability for damages whatsoever upon the release of this information.

Signed:____

Today's Date:____

Cell phone:____

Date of Birth:____

Former Names: Please list below.

____

____

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Please include a copy or picture of your current Driver's License

for the Criminal History/Background Check Report.