



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.

Professional Licensing/Work Experience/Education

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?

If professionally licensed, is your license currently active in the state of Indiana? Yes No
(Please include a copy of all licensures and certifications.)

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: _____

**Please include a copy or picture of your current Driver's License
for the Criminal History/Background Check Report.**

