



Clínica Esperanza/ Hope Clinic
60 Valley Street, Suite 104
Providence, RI 02909
www.aplacetobehealthy.org

Volunteer Application Form (Non-Provider)

Date: _____

Clínica Esperanza/Hope Clinic’s mission is to provide primary health care and preventive health services to adults and children living in Rhode Island who do not have health insurance or cannot afford to purchase health care. The majority of our clients do not speak English as a first language; therefore, we emphasize linguistically competent, culturally attuned care.

Approval Signature: Annie De Groot M.D.

All information must be completed. Please include area codes for ALL phone numbers. Please fill out the form, include your name and the date in the file name, upload it (along with the other materials) to the [Google Form](#).

PERSONAL INFORMATION

Date of Birth: _____ Age: _____ Preferred Pronouns: _____
Month/Day/Year

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Alternate email (if applicable): _____

EMERGENCY CONTACTS

Contact #1

Name: _____ Phone #: _____

Alternate Phone #: _____ Relationship: _____

Contact #2

Name: _____ Phone #: _____

Alternate Phone #: _____ Relationship: _____

Contact #3

Name: _____ Phone #: _____

Alternate Phone #: _____ Relationship: _____



EDUCATION

HIGH SCHOOL

Name of High School: _____ Location: _____

Current Grade (if applicable): _____ Graduated? Yes No

Year of Graduation: _____

UNDERGRADUATE

Name of College/University: _____ Location: _____

Major(s): _____ Minor(s): _____

Other programs (if applicable): _____

Last year completed: _____ Current Year: _____ Graduated? Yes No

Year of Graduation: _____

GRADUATE

Name of Graduate School: _____ Location: _____

Program of Study: _____

Last year completed: _____ Current Year: _____ Graduated? Yes No

Year of Graduation: _____

Please list any other specialty education or training you may have received and any other specialized skills you have. Be sure to include all dates (if applicable)



EMPLOYMENT HISTORY

Please list newest to oldest. If you still work at any employer listed below, please write "Present" in the "End Date" space.

Employer Name (Company): _____ Type of Business: _____

Supervisor Name: _____ Business Phone #: _____

Dates Worked: _____ to _____ Type of Employment: Full-time Part-time
Start Date End Date

Employer Name (Company): _____ Type of Business: _____

Supervisor Name: _____ Business Phone #: _____

Dates Worked: _____ to _____ Type of Employment: Full-time Part-time
Start Date End Date

Employer Name (Company): _____ Type of Business: _____

Supervisor Name: _____ Business Phone #: _____

Dates Worked: _____ to _____ Type of Employment: Full-time Part-time
Start Date End Date

REFERENCES

Please list business, professional, or counselor/teacher references of individuals who are not related to you.

Reference #1

Name: _____ Title: _____

Organization/Company Name: _____

Phone #: _____ Extension (if applicable): _____

Email: _____

Reference #2

Name: _____ Title: _____

Organization/Company Name: _____

Phone #: _____ Extension (if applicable): _____

Email: _____

Reference #3 (optional)

Name: _____ Title: _____

Organization/Company Name: _____

Phone #: _____ Extension (if applicable): _____

Email: _____



Please answer the following questions:

Are you volunteering for a course, program, or community organization? Yes No

If **YES**, how long do you plan to volunteer? _____

Name of course/program/organization: _____ Location: _____

Is there someone we can contact at the school, program, or community organization? Yes No

If **YES**, please include their contact information below.

Name: _____ Title: _____

Phone #: _____ Ext (if applicable): _____

Email: _____

Do you speak any languages besides English? Yes No

If **YES**, please list the language(s) and level of proficiency:

Please list any other volunteer experience you have. **Please include dates!**

Please list any special skills, interests, and/or other hobbies:



VOLUNTEER QUESTIONS

How did you hear of our volunteer program?

Why do you wish to volunteer?

What do you expect or need from this experience?

What type of volunteer work are you interested in?

Have you ever been convicted of a felony? Yes No

If **YES**, explain,



- I understand that my volunteer work is contingent upon my completing of a communicable disease Health Record and obtaining a PPD Test (Tuberculin Tine Test) and a background check.
- I agree to maintain strict patient confidentiality in my position as a volunteer.
- I understand that any false statements, concealment or withholding of information on this application or in any aspect of the application process is sufficient cause for withdrawing an offer to participate in the volunteer program or dismissal if I am already placed in a volunteer position.

SIGNATURE:

DATE:

FOR OFFICE USE ONLY:			
<i>Placement:</i>		<i>Supervisor:</i>	
<i>Assigned Day (s):</i>		<i>Assigned Hours:</i>	<i>Orientation Date:</i>
<i>Training Date:</i>		<i>START DATE:</i>	<i>TERMINATION DATE:</i>
<i>Interview Initials:</i>			
<i>Immunization:</i>			
<i>PPD Test</i>	<i>Rubella</i>	<i>MMR</i>	
<i>Date:</i>	<i>Date:</i>	<i>Date:</i>	