

Olde Towne Medical Center



Volunteer Program Application

First Name: _____ Last Name: _____

Home Address: _____ Home Phone: _____

e- mail Address: _____ Cell Phone: _____

Current Occupation: _____ Emergency Contact: _____ Emergency Phone: _____

Please list skills or areas of expertise that you feel would be of assistance to OTMC. _____ List Other _____

<input type="checkbox"/> Advanced PC skills	<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Basic PC skills	<input type="checkbox"/> Dentist	<input type="checkbox"/> Physician 1. _____
<input type="checkbox"/> Bookkeeper/accountant	<input type="checkbox"/> Filing	<input type="checkbox"/> RN
<input type="checkbox"/> Clerical	<input type="checkbox"/> Fundraising	<input type="checkbox"/> Reception 2. _____
<input type="checkbox"/> CNA	<input type="checkbox"/> Lab work	<input type="checkbox"/> Telephoning
<input type="checkbox"/> Dental Assistant	<input type="checkbox"/> LPN	<input type="checkbox"/> Translation 3. _____

I am also interested in being considered for:

<input type="checkbox"/> Administrative Support Volunteer -- for staff and volunteers	<input type="checkbox"/> Immunization Clinic
<input type="checkbox"/> Event Volunteer - support for special events, Back to School Clinic, Pap Clinic, etc.	<input type="checkbox"/> Medication Access Program
<input type="checkbox"/> On-Call Volunteer -- to provide last minute administrative support or event support	<input type="checkbox"/> Information Desk

Please list any current volunteer positions or club affiliations: _____

Have you ever been convicted of a law violation(s), including moving traffic violation(s)? Yes No

If yes, please describe the offense(s): _____

Date of charge: _____ Date of conviction: _____

Statute/Ordinance (if known) _____ County/City & State of conviction: _____

Please indicate the days and hours you can be available to volunteer.

<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday
# hours _____	# hours _____	# hours _____	# hours _____	# hours _____
_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____

STATEMENT OF AGREEMENT

I hereby certify that all entries on this application are true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part to any rights in service to Olde Towne Medical Center.

Signature _____ Date _____

Olde Towne Medical Center is located in the James City County Human Services Building.
Williamsburg Area Transit bus service is available.

Please return completed application to Volunteer Coordinator:
Olde Towne Medical Center, 5249 Olde Towne Road, Williamsburg, VA 23188
757-259-3258 (phone) 757-220-1953 (fax) www.oldtownemedicalcenter.org