

1260 Hwy 54 West, Suite 100 Fayetteville, GA 30214 Phone: 770-719-4620

FAX: 770-719-4622

Volunteer Application Lay Personnel

Name			
	(Last)	(First)	(Middle)
Mailing Address:			
	(Street)		
DI (II	(City)	W. 1 (G.11)	(Zip)
Phone: (Home)_		Work/Cell)	
E-mail:			
Date of Birth:			
Area of interest:	receptionist	front of	fice with EPIC experience
	patient greeter	interpre	eter
	fundraising event support	marketi	ing, social media/email blast campaigns
Skills (i.e. compu	iter, education, foreign language	e, fundraising,	technology, etc.)

VOLUNTEER SERVICE AVAILABILITY:

Clinic hours vary during the week. Office hours are 8:30 am until 8:30 pm on Monday, Tuesday, and Thursday; 8:30 am until 4:30 pm on Wednesday. Please indicate the times you will be available.

	Monday	Tuesday	Wednesday	Thursday
Day				
Evening				

VOLUNTEER REQUIREMENTS AND REFERENCES:

Are :	you completing these volunteer hours for school or other community requirement?Ye If so, please complete the following:	s No
	School / Community organization:	
	Church or Congregation (if applicable):	
	Requirements of volunteer experience (necessary hours, duties, etc.):	
	Supervisor's name, title and phone number:	
Pleas	ase List References:	
1	phone	
2	phone	
	Please attach any necessary paperwork	
EM	IERGENCY CONTACT INFORMATION:	
Nan	meRelationship	
Add	dress	
Pho	one Number	
	information is accurate to the best of my knowledge. I acknowledge a 1-year commitmen equired.	t for EPIC access
SIG	GNATURE OF VOLUNTEER	
DA	TE	