FAYETTE C.A.R.E.
CLINIC
COMPASSION AND RESPECT FOR EVERYONE

1260 Hwy 54 West, Suite 100
Fayetteville, GA 30214
Phone: 770-719-4620
Fax: 770-719-4622

Volunteer Application
Medical / Dental Personnel

Name: _____ Dr. ____ Mr. ____Mrs. ____Ms.____Date: _____

Phone: (H)_____(Mobile)_____E-mail:_____

Address: _____ City: _____ Zip: _____

DOB:_____ Employer: _____

How did you hear about Fayette CARE Clinic? _____

Title: ___Physician ___Dentist ___APRN ___PA ___Pharmacist ___RN
___LPN ___CMA (back-office) ___Other_____

Status: ___Retired ___Actively Practicing Specialty: _____

License Number: _____ Active / Inactive Expiration: _____

DEA Number: _____
You must provide a copy of your current license

Liability carrier: _____ Policy Number: _____

VOLUNTEER SERVICE AVAILABILITY: Volunteer start date: _____€

I can serve one shift: ___ per week ___ every other week ___ per month ___ every other month

Clinic hours for Monday, Tuesday and Thursday are 8:30AM to 9:00PM and Wednesday from 8:30AM to 4:30PM. Please indicate below the hours you can volunteer.

Monday	Tuesday	Wednesday	Thursday
Day			
Evening			

Please List References:

Professional:

1. _____phone_____

2. _____phone_____

Personal:

1. _____phone_____

2. _____phone_____

What is your goal for volunteering? _____

Are you completing these volunteer hours for school or other community requirement? _____Yes _____No
If so, please complete the following:

School: _____

Area of Study: _____

Requirements of volunteer experience (necessary hours, duties, etc.):_____

_____

_____

Date that requirements must be complete/end date: _____

Supervisor's name, title and phone number_____

_____

Please attach any necessary paperwork

EMERGENCY CONTACT INFORMATION:

Name_____ Relationship_____

Address_____

Phone Number_____

All information is accurate to the best of my knowledge

SIGNATURE OF VOLUNTEER_____**DATE**_____