FULTON COUNTY HEALTH DEPARTMENT
VOLUNTEER APPLICATION
125 East 9th Street – Rochester, IN 46975
Please PRINT clearly!

Contact Information

Name:_____

Street Address_____

City, State, Zip code_____

Home Phone_____Cell phone_____

Email Address _____
_____

Employment Information

Occupation_____

Employer _____

Employer Address_____

Education
(Check all that apply)
___H.S. diploma: School_____City/St._____
            Year_____
___Undergrad degree: School_____City/St._____
            Year_____Major_____
___Grad degree: School_____City/St.
            Year_____Major_____
Educational Training/Licenses or Certifications(list all applicable degrees &
credentials)_____
_____

SERVICE OPPORTUNITIES

What do you want to do? Order your interests by NUMBER (first choice =1, second choice =2, etc.

___Front desk/registration
___Medical clinic assistant
___Clerical support
___Computer work
___Pharmacy technician
___Waiting room coordinator
___Patient education (smoking cessation, nutrition education, disease
     management)
___Janitorial duties
___Patient advocate
___Vaccinator (Medical Personnel)

Please summarize any special skills or qualifications you may have acquired from employment, previous volunteer service, or through other activities, including hobbies:

Medical Personnel

Are you a healthcare professional?   □ Yes   □ No

Professional License Type (RN, MD, PD, etc.):_____

Professional License Status: □ Active   □ Expired

Professional License Number: _____
Professional License Expiration Date: _____

PLEASE ATTACH A PHOTOCOPY OF YOUR CURRENT PROFESSIONAL LICENSES

Availability

Please check the times you are available to volunteer:

____Weekday mornings   ___Weekly
____Weekday afternoons   ___Bi-weekly (every other week)
____Weekday evenings   ___Monthly (once a month)
                              ___Bi-monthly (every other month
                              ___Other_____

Agreement & Signature

By submitting this application, I affirm that the facts set forth in this application are true and complete. I also give permission for Fulton County Health Department to contact my employer.

Name (printed):_____

Signature_____

Date:_____