Western Tidewater
FREE CLINIC
Helping Hands. Health. Hope.

Volunteer Application -Professionals

Personal Information:

Full Name ____
(last) (first) (middle initial)

Soc. Sec. # ____________________ Date of Birth _________________ Today's Date ____________________________

Address ______________________________________ City ______________________ Zip _______________________

Home Phone _____________________ Work Phone _____________________ Cell Phone _________________________

E-Mail Address ____

Emergency Contact: ____
(name) (relationship) (Phone)

Volunteer Information:

1. How many times a month would you like to volunteer? (Please circle one)
   Once 2-3 4-5 6-7 8-9 More than 10

2. Which days of the week do **you prefer** to volunteer? (Please **circle all** that apply)
   Monday Tuesday Wednesday Thursday Friday

3. Please let us know the days **you will not be available** to volunteer. (Please **circle all** that apply)
   Monday Tuesday Wednesday Thursday Friday

4. Please select the time(s) you wish to volunteer (Please **circle all** that apply)
   Mornings Afternoons Evenings On call as needed

5. Are you active military/reserves? Yes No

6. Do you file a Virginia State Tax return? Yes No

7. Please complete one line per Professional License/Certificate/Qualification you currently hold:

MD DO DDS RN NP PA LPN License number: ____________________ State Licensed: ______________________
LPC CSAS LCSW QMHP OTHER

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If you have a professional license, you are protected from liability if you are practicing within the scope of your license without compensation at a free clinic through the Virginia Division of Risk Management. You can only be sued for willful negligence. In order to establish this protection. **WE MUST HAVE A COPY OF YOUR PROFESSIONAL LICENSE ON FILE.**

I understand the above statement. __________________________________ Date ____________________
Signature required

ATTENTION PHYSICIANS:
For referrals please indicate the number of patients ____ per week or month (circle one)
Where would von like to see referrals? ___________ WTFC ___________ My office

Please return your completed application to: Western Tidewater Free Clinic
2019 Meade Parkway,
Suffolk, VA 23434