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 you like to see referrals? _____WTFC _____My office

Please return your completed application to: Western Tidewater Free Clinic
3000 Godwin Blvd.
Suffolk, Va. 23434