Wilmington Community Clinic
1009 N. Avalon Boulevard, Wilmington, CA 90744
Phone: (310) 549-5760 Fax: (310) 549-2277 Email: info@wilmingtoncc.org

Wilmington Community Clinic Volunteer Form

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact Name _____

Emergency Phone _____ Emergency Cell _____

How did you hear about Wilmington Community Clinic?

_____

If you have a specific volunteer position in mind, please describe: _____

_____

What is your reason for volunteering and what do you hope to gain from your experience? _____

_____

How soon are you available to start volunteering? _____

What is your availability in terms of days and hours?

_____

_____

Please list any licenses or certificates (e.g. CPR, MD, RN, CNA, etc.) relevant to your desired volunteer position:

_____

Please describe any skills, experience, or education you may have (e.g. diabetes education, mental health worker, receptionist, clerical, etc.) that may be relevant to your desired volunteer position:

_____

_____

_____

Foreign language abilities:

_____

Additional information or comments:

_____

_____

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Volunteer Expectations:

I understand that this is a volunteer position and all services provided in this capacity will be performed without compensation.
I understand that this is solely a volunteer position and will not lead to a permanent position or a paid position within WCC.
I agree to successfully complete all volunteer requirements and paperwork.
I agree to provide proof of physical exam and negative TB test each year. If I do not have current proof, I am eligible to complete these tests at Wilmington Community Clinic.
I agree to provide proof of any applicable licenses.
I agree to treat all patients, volunteers and staff with dignity, respect and courtesy.
I agree to observe patient confidentiality per HIPAA guidelines.
I agree to attend required training sessions and meetings.
I agree to respect the policies, rules and regulations of WCC.
I understand that my application is subject to a complete background review.
I understand that if I do not follow the above expectations, that I may be dismissed from my duties at any time.

I hereby agree to the above Volunteer Expectations, give permission to conduct a background review and submit my application for a volunteer position:

Printed Name _____ Date _____
Signature _____

How to Submit Forms:
Please submit completed Volunteer Application to:
Wilmington Community Clinic
Attn: Carol Martinez
1009 N. Avalon Blvd.
Wilmington, CA 90744
Phone: (310) 549-5760 Fax: (310) 549-2277
Email: cmartinez@wilmingtoncc.org
Website: www.wilmingtoncc.org