

# I Care San Antonio Volunteer Application

## Contact Information

Name: \_\_\_\_\_  
(Last, First , MI)

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Business Phone# \_\_\_\_\_ E-mail: \_\_\_\_\_

Drivers License: \_\_\_\_\_ Do you have a Pass port \_\_\_ Yes \_\_\_ No

Preferred method of contact: \_\_\_ E-mail \_\_\_ Cell Phone \_\_\_ Home Phone \_\_\_ Business Phone

Preferred time to be contacted: \_\_\_ A.M.. \_\_\_ P.M. \_\_\_ After 5:00pm \_\_\_ Anytime

## Emergency Contact Information

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

## Employment Contact Information

I am: \_\_\_ Employed \_\_\_ Unemployed \_\_\_ Retired \_\_\_ Student \_\_\_ Other (Please check those that apply) \_\_\_\_\_

Current Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Position Interest Information \_\_\_\_\_

## Please check the position(s) you would like to volunteer for:

\_\_\_ Clinician (Physician , Optometrist) \_\_\_ Nurse \_\_\_ technician \_\_\_ Receptionist \_\_\_ Optician \_\_\_ Translator

\_\_\_ Special Projects( fund-raising, work projects, clerical, special events)

\_\_\_ Special Expertise ( knowledge of computers, foreign languages, grant writing, etc.)

Do you have any previous volunteer experience? \_\_\_\_\_

(Where and when)

## Educational Training / Licenses or Certifications (list all applicable degrees & credentials including CPR/ ACLS)

\_\_\_\_\_  
\_\_\_\_\_

\*We will need copies of State Licenses, malpractice insurance and copies of renewals.

**Reference:** Name, How are you acquainted with this person, (Must not be a relative) and Phone number

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Information Requested from Medical Staff**

	Yes	No
Have you ever been notified by a state licensing board of charges against you?	_____	_____
Have any of your licenses or certificates to practice ever been restricted, revoked, suspended, limited, surrendered, canceled or has there been any other disciplinary action against your licenses or certificates?	_____	_____
Have your hospital staff privileges ever been limited or removed?	_____	_____
Has a Drug Enforcement Administration ever withdrawn your DEA number or warned you?	_____	_____

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**Personal Information**

	Yes	No
Do you have any limitations or medical conditions we should be aware of ?	_____	_____
Have you ever been convicted of a felony or a criminal offense?	_____	_____

If you answered yes to any of the questions above please indicate where and what it entailed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Confidentiality**

I, the under signed, understand and agree to the following as a volunteer of I Care San Antonio:

I am aware that I will come in contact with confidential information and that it is my responsibility to maintain this confidentiality in accordance with the HIPAA and ICESA policies and procedures. I further understand that in the case of breach of confidentiality, I should expect termination from the volunteer program.

I certify that: The above information is complete and accurate. I also understand and agree with the confidentiality statement.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that my services are being offered on a voluntary basis, without anticipation of financial remuneration, and I shall indemnify and hold harmless I Care San Antonio, its boards and their officers, agents and employees, from and against all claims, demands, loss or liability of any kind or nature for possible injury during volunteer service.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian of applicant:

\_\_\_\_\_ Date \_\_\_\_\_

Relation to applicant \_\_\_\_\_