



marin community clinics  
connecting for health

### VOLUNTEER REGISTRATION

**Please attach resume**

Marin Community Clinics

Phone: (415) 798-3170

Fax: (415) 798-3180

Email: Volunteer@marinclinic.org

First Name _____	Last Name _____	Date _____
Home Address _____	Home phone _____	
City & Zip Code _____	Business phone _____	
E-mail address _____	Cell phone _____	
Male _____	Female _____	Pager _____

<u>Education</u> (mark last year)	
High School: 1   2   3   4   Where? _____	College: 1   2   3   4   Where? _____
Graduate: 1   2   3   4   Where? _____	

Previous work experience \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you presently employed? no \_\_\_\_\_ yes \_\_\_\_\_ If yes, how many hours worked per week? \_\_\_\_\_

Where do you work? \_\_\_\_\_

Special skills, training, interests or hobbies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous volunteer jobs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What kind of volunteer jobs are you interested in? \_\_\_\_\_  
\_\_\_\_\_

What are your volunteer goals? \_\_\_\_\_  
\_\_\_\_\_

What time do you have available?

Total hours per week available \_\_\_\_\_

Days available \_\_\_\_\_

Preferred hours \_\_\_\_\_

Days not available \_\_\_\_\_

Preferred Days \_\_\_\_\_

Dates Available from \_\_\_\_\_ to \_\_\_\_\_

Please give us any further information or comments you might wish to offer: \_\_\_\_\_

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

### EMERGENCY INFORMATION

Please PRINT clearly

Volunteer Name \_\_\_\_\_

Volunteer Signature \_\_\_\_\_

(Parent or guardian signature if under 18 years old)

Please list three people who can be contacted in case of emergency:

Name	Relationship	Work phone #	Cell phone #	Home phone #
1.				
2.				
3.				

Please list three references (academic or professional):

Name	Relationship	Work phone #	Cell phone #	Home phone #
1.				
2.				
3.				