VOLUNTEER and INTERN APPLICATION

Volunteer Type *(please check one):*

- ☐ Intern
- ☐ Volunteer
- ☐ Licensed Medical Professional

PLEASE PRINT OR TYPE

PERSONAL INFORMATION

Date of Application: ____________________

Name: ____

Address: ____

City, State, Zip: ____

Primary Phone #: _____________________________________ ☐ Home ☐ Cell ☐ Business

Secondary Phone # (optional): __________________________ ☐ Home ☐ Cell ☐ Business

E-mail Address: ____

Have you spoken with an employee of Colorado Coalition for the Homeless already?

☐ Yes ☐ No

If yes, please list the employee's name and program? ___________________________________

Are you under age 18? ☐ Yes ☐ No

PLEASE LIST THE VOLUNTEER or INTERN POSITION(S) YOU ARE APPLYING FOR

(a list of available volunteer and intern opportunities are posted on the volunteer page of our website at www.coloradocoalition.org

1st Choice: Volunteer or Intern Job Title: ____

2nd Choice: Volunteer or Intern Job Title: ____

3rd Choice: Volunteer or Intern Job Title: ____

Other: ____

EMPLOYMENT and/or VOLUNTEER EXPERIENCE

FIRST:

Name of Employer or Volunteer Agency: ____

Address, City, State, Zip: ____

Job or Volunteer Title: ____

Responsibilities: ____

Start Date: _________________________ **Completion Date:** _________________________

Reason for Leaving: ____

SECOND:

Name of Employer or Volunteer Agency: ____

Address, City, State, Zip: ____

Job or Volunteer Title: ____

Responsibilities: ____

Start Date: _________________________ **Completion Date:** _________________________

Reason for Leaving: ____

PERSONAL REFERENCES (non relatives)

FIRST:

Name: ____

Relationship: ____

Primary Phone #: ____

E-mail: ____

SECOND:

Name: ____

Relationship: ____

Primary Phone #: ____

E-mail: ____

AVAILABILITY

Time Commitment:

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other _____________

Days / Hours available to volunteer (please check all that apply):

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

How many hours are you interested in volunteering: Weekly? _______ **or** Monthly? _______

When are you available to start volunteering? ____

Are you willing to drive your personal vehicle to transport clients? ☐ Yes ☐ No

Languages Spoken: ____

EMERGENCY CONTACT INFORMATION

Name: ____

Relationship: ____

Address, City, State, Zip: ____

Primary Phone #: ____________________________________ ☐ Home ☐ Cell ☐ Business

Secondary Phone # (optional): _________________________ ☐ Home ☐ Cell ☐ Business

Medical Conditions or Allergies (optional): ____

I certify the above statements are true and correct to the best of my knowledge. I understand as part of my application to volunteer a background check will be completed in accordance with the requirements of the position in which I serve. This may include central Registry of Child Protection, fingerprinting, motor vehicle record, criminal background check, and references listed herin.

I further understand the Colorado Coalition for the Homeless has a mission to work collaboratively toward creating lasting solutions for homelessness. In my interations with this agency I will strive to support this mission.

Signed: ____ Date: _______________________

* **Interns and Medical Practitioners** complete page #4 *

INTERNS and MEDICAL PRACTITIONERS ONLY

INTERN INFORMATION

Name of College/University: ______________________________

College/University's Address: ______________________________

City, State, Zip: ______________________________

Program of Study: ______________________________

Name of School Advisor/Field Placement Coordinator: ______________________________

Advisor/Coordinator's Phone #: ______________________________

Advisor/Coordinator's E-mail: ______________________________

Total Internship Hours Needed to Complete: ______________________________

Anticipated Start Date: __________________ **Anticipated End Date:** __________________

MEDICAL / CLINICAL INTERNS, Please check preferred clinic:

☐ Stout Street Clinic ☐ Samaritan House Clinic ☐ Pharmacy ☐ Eye Clinic ☐ Dental Clinic

MEDICAL PRACTITIONER INFORMATION

Occupation / Field of Licensure: ______________________________

List all graduate, university, and professional schools attended:

University Name: ______________________ **Year of Graduation**: ____________

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University Name: ______________________ **Year of Graduation**: ____________

Please Check Preffered Clinic:

☐ Stout Street Clinic ☐ Samaritan House Clinic ☐ Eye Clinic ☐ Dental Clinic ☐ Pharmacy

MEDICAL PRACTITIONERS MUST ATTACH

Proof of current licensure

Proof of current malpractice insurance coverage