Mail Application to:
Virginia B. Andes Volunteer Community Clinic
Director of Volunteers
21297 Olean Boulevard – B
Port Charlotte, FL 33952
Tel: 941-766-9570

(Please print, fill out and mail this form to us.)

Name: _____

Phone: _____ Cell: _____

Address: _____

_____

Email Address: _____

Birthday: _____

Applicant's Background (type of jobs held, skills in working with people, computer skills, etc.):

_____

_____

_____

_____

Applicant's Area of Volunteer Interest:

____Pharmacist	___Pharmacy Technician	___Pharmacy Screener
____Front Office Work	___Nurse	___Pharmacy Dispenser
____Patient Advocate	___Pharmacy Stocker	___Pharmacy Courier

Volunteer is here year-round_____ Volunteer is here only from _____ to_____

We ask a minimum commitment of one four-hour shift per week (you may work more if you desire)

Circle which days of the week would work best for you: Mon., Tues., Wed., Thurs., Fri.

Check all that apply: ____Mornings 9-1 pm, ____Afternoons 1-5 pm, ____Evenings 5-9 pm

For internal office use only:

_____

_____

Date Volunteer competed the Fingerprinting: _____

Department Volunteer Assigned to:_____

Contact Attempts: _____