

VOLUNTEERS IN MEDICINE

423 Route 9 North, Cape May Court House, NJ 08210

Volunteer Application

PLEASE PRINT

Name: _____
(LAST) (FIRST) (INITIAL)

Phone: _____ Cell: _____ E-mail: _____

Address: _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

• **PLEASE CHECK ALL SKILLS THAT MAY APPLY**

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Data Entry |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Filing |
| <input type="checkbox"/> Administrative | <input type="checkbox"/> Receptionist | <input type="checkbox"/> Fundraising | <input type="checkbox"/> Maintenance |
| <input type="checkbox"/> Computer programs I am familiar with: _____ | | | |

• **IF YOUR POSITION REQUIRES LICENSURE**

License No: _____ Date of Expiration: _____

Additional certifications: _____

Additional languages spoken: _____

• **AVAILABILITY**

1. How many hours per week/month would you typically be able to volunteer? _____
2. What **days** of the week (Mon. – Fri.) and at what **time** on those days would you be able to work? _____

3. What date would be able to start as a volunteer? _____

• **HOW DID YOU HEAR ABOUT VIM**

• **SIGNATURE AND DATE**

(NAME)

(DATE)

Thank you for your interest. Please drop off your application in person during regular business hours, mail it to the address above, or fax it to the attention of the Director, Clinical Operations at: (609) 463-2830