

# DISCIPLES CLINIC OF ATHENS

## DOCTOR VOLUNTEERS

Date: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Day(s) Available: Mon \_\_\_ Tue \_\_\_ Wed \_\_\_ Thu \_\_\_ Fri \_\_\_ Sat \_\_\_

Times Available: Mornings \_\_\_ Afternoons \_\_\_ Evenings \_\_\_

Type of Practice: \_\_\_\_\_ Retired: Yes \_\_\_ No \_\_\_

License Number: \_\_\_\_\_ Hospital Affiliation (If Any): \_\_\_\_\_

Professional Address:

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

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

### How often would you like to volunteer (3 – 4 Hour Shifts):

Once a month: \_\_\_ Once every two months: \_\_\_ Once every three months: \_\_\_ More Often: \_\_\_

### Insurance Information:

Carrier: \_\_\_\_\_ Medical License Number: \_\_\_\_\_

Is coverage restricted to your Primary Practice: Yes \_\_\_ No \_\_\_

Language (Other than English): \_\_\_\_\_

Ever been convicted of a Felony: Yes \_\_\_ No \_\_\_

Previous Employment or Volunteer Service: \_\_\_\_\_

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

Please mail or Fax completed form to:

### DISCIPLES CLINIC OF ATHENS

P.O. BOX 1757

ATHENS TX.75751

PH: 903-677-3604

www.disciplesclinic.org

FAX: 903-676-3605