



**ITHACA FREE CLINIC
VOLUNTEER PROVIDER APPLICATION**

(Please print legibly)

Date: _____

Name: _____

Title(s)/Licensure/Certifications: _____

1. Contact information (Please * the best way to contact you)

Mailing Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Employer: _____ Occupation: _____

Email Address: _____

2. Supplemental Materials (Please include the following in your application)

- Resume or CV
- Names and Contact information for 3 references
- Copies of current state licenses and other certifications

3. Availability: (Please indicate your preference of BOTH Number of Hours and Frequency)

Number of Hours

Frequency

2 hrs/week

2 Once a month

4 hours/ week

4 Twice a month

Other: _____

Other _____

For Office Use Only:

F Supplemental Materials ALL received, copies on file: Date: _____

S References cleared: 1) _____ 2) _____ 3) _____

R Provider contacted for scheduling (days available): M P T P Th P Other arrangement

P Date of 1st shift: _____

Discontinued (date & reason) _____

Contact Log: