



P.O. Box 153 Fishersville, Virginia 22929-0153 (540) 332-5607 or 932-5606

## COMMUNITY VOLUNTEER SIGN-UP FORM

**NAME**

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**MAILING ADDRESS**

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**DAY TELEPHONE** \_\_\_\_\_

**E-MAIL** \_\_\_\_\_

**I AM INTERESTED IN VOLUNTEERING:**

\_\_\_ **ON CLINIC NIGHT**    \_\_\_ **WEEKDAYS**    \_\_\_ **SPECIAL NEEDS**

**RELEVANT EXPERIENCE:**

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**REFERENCE:**

**NAME:**

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**ADDRESS:**

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**TELEPHONE:** \_\_\_\_\_

FOR OFFICE USE ONLY: Rec \_\_\_\_\_ Rolodex \_\_\_\_\_ Computer \_\_\_\_\_ Scheduled \_\_\_\_\_

Rev. 6/25/07



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## CONFIDENTIALITY STATEMENT

All volunteers with the Augusta Regional Free Clinic must understand and agree that they **CANNOT** repeat ANY information they learn about any patient. The Board of Directors believes strongly in the responsibility of everyone working in a health care setting to maintain **STRICT CONFIDENTIALITY** about patient matters. Any reason to suspect a volunteer has breached this trust puts the Augusta Regional Free Clinic at risk, and will result in that person no longer being a part of the Free Clinic.

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Signature

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Date

FAX: (540) 332/032-5610 - EMAIL: [afreeclinic@ntelos.net](mailto:afreeclinic@ntelos.net)  
Website: [www.afreeclinic.org](http://www.afreeclinic.org)

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