VOLUNTEER INFORMATION FORM

Name: ____

Address:____

____

Phone #: ______________ **Cell Phone #:** _____________ **Email:** ______________________

Emergency Contact Name: ____________________________ **Phone:** __________________

Birth Date: ___/___/_____

Volunteer Position: __________________________________

Organization (If applicable):____________________________

License # (If applicable): ______________________________

Personal Reference Name: ______________________________

Address: ______________________________

Phone & Email: _________________________

Professional Reference Name: _____________________________

Address: ______________________________

Phone & Email: _________________________

Please email the completed form to info@melleamanfreeclinic.org, fax to 276-781-0866, mail to 601 Radio Hill Rd, Marion, VA 24354, or drop it off at the front desk in the MLFC.

We appreciate your interest in becoming a volunteer!