



ZIAD Healthcare for the Underserved Inc.
1640 Fort Street, Suite E
Trenton, MI 48183
Office (313) 815-8767 Fax (810) 458-4187

Volunteer Application Packet

Dear Prospective Volunteer:

Thank you for expressing an interest in volunteering to assist ZIAD, Healthcare for the Underserved, Inc. in seeking a volunteer service position to further our mission. We take great pride in our success stories, but could not do this without the assistance of the community and **VOLUNTEERS!**

Attached is our volunteer application. Your application will be complete when you have included the following items, submitted in one packet:

- _____ The application completed.
- _____ Two completed reference forms (in separate sealed envelopes – see Reference Check Form for instructions)
- _____ Copies of current licenses and/or certificates (if required)

PLEASE DO NOT SUBMIT YOUR APPLICATION UNTIL ALL COMPONENTS HAVE BEEN FULLY COMPLETED. We cannot proceed with volunteer placement in our organization until all application materials have been received. Thanks for your cooperation!

SEND or Fax ALL COMPLETED APPLICATIONS TO:

Ibrahim Ahmed, PhD, ND, RN
ZIAD Healthcare for the Underserved, Inc.
Executive Director
PO Box 489
Linden, Michigan 48451
Fax 810-458-4187

We appreciate your response to our call to action as a volunteer, in cooperation with our providers, pilot programs, and affiliates. I would like to thank you in advance on behalf of our Board of Directors, volunteer staff, and the patients in which you may have the opportunity to serve for your dedication through volunteerism.

Sincerely,

Ibrahim Ahmed
Executive Director
ZIAD, Healthcare for the Underserved, Inc.

ZIAD, Healthcare for the Underserved, Inc.

Volunteer Application

Please PRINT clearly!

Name: _____ Preferred Nickname: _____ Date: _____

Home Phone: _____ Cell: _____ Business: _____

E-Mail: _____

Preferred method of contact: Home Business E-mail Any

CURRENT or MAILING ADDRESS

Address: _____ City/State: _____ Zip: _____

PERMANENT ADDRESS (if different)

Address: _____ City/State: _____ Zip: _____

EMPLOYMENT INFORMATION

I am: Employed Un-employed Retired Student

Employer /School _____ Occupation _____

Employer Address _____ Department/Suite Number _____

City/State _____ Zip _____ Business Phone _____

Professional Employment / Practice History

Date Started _____ Date Ended Position _____

EDUCATION

(Check all that apply – *please note degrees in progress*)

H.S. diploma: School _____ City/St. _____ Yr _____

Undergrad degree: School _____ City/St. _____ Yr _____ Major _____

Grad degree: School _____ City/St. _____ Yr _____ Major _____

Educational Training / Licenses or Certifications (list all applicable degrees & credentials):

**** PLEASE ATTACH A PHOTOCOPY OF YOUR CURRENT PROFESSIONAL LICENSES. ****
FOR STATISTICAL PURPOSES ONLY – Please Complete

Responsibilities

I am age 18 or older **Birth**day: _____ **Ethnicity**: _____ **Gender**: _____

Any languages other than English (including sign language) _____

Do you have any special needs or health concerns that we need to be aware of?

SERVICE OPPORTUNITIES

Please Volunteer for one or more opportunities: Indicate your interests by NUMBER (first choice = 1, second choice = 2, etc.). For job descriptions, requirements, and time commitments, please contact the director for further information.

MEDICAL CLINIC

- Prescription Drug Intake (Frail Elderly Pilot Program)
- Patient Assessment/Intake
- Social Worker
- Certified Medical Clinic Assistant
- Medical Clerical Support Projects
- Medical Clinic RN / LPN
- Physician Assistant

ADMINISTRATIVE

- Phone Assistance/Intake
- Medical Administrative Asst.
- Community Liaison
- Other _____

COMMUNITY BACKGROUND

(Must be 18 years and older)

Have you volunteered before? Yes/No
If yes, when?, where? What did you do?

How did you hear about ZIAD? What attracted you to service with ZIAD?

Is there anything else you would like us to know about you (i.e., career goals, skills, etc.)?

How often would you like to volunteer?

- one time
- specific project
- 1-2 times per month
- 1x / week 2x / week more than 2x / week

How long of a commitment can you make as a volunteer? 3 months 6 months 9 months
 more than 1 year.

PLEASE LIST THE TIMES YOU ARE AVAILABLE TO VOLUNTEER BELOW

Monday Tuesday Wednesday Thursday Friday

Hours available:

PRIVACY POLICY AND BACKGROUND CHECK

I agree to the privacy policies of ZIAD Healthcare for the Underserved, Inc and those affiliates, companies, and other organizations that have relationships with ZIAD in keeping with and conforming to all state, local, and health authorities. I, the undersigned, further agree to a background check for the purposes of volunteering for any position that I may perform with ZIAD, Healthcare for the Underserved, Inc.

It is my understanding that I may be asked to sign additional waivers and privacy statements before beginning as a volunteer.

Signature of Applicant

Date:

I agree to a background check

Signature _____ *date* _____

For ZIAD Healthcare for the Underserved, Inc. only- do not write below.

Satisfactory _____ *Unsatisfactory* _____

Accepted _____ *Not Accepted* _____

Assigned to _____

Initial days and hours _____

Location assigned: _____

Review date: _____

ZIAD signature authorization

A Minimum of TWO references MUST be provided.

*Both Volunteer Professional Reference Check Forms must be attached **with** your application.

FOR OFFICE USE ONLY

App Rec: _____ Entered: _____ Refs: 1 2 3 Orient/Mtg: _____ Start Date/Active: _____

Comments: _____

Volunteer Professional Reference Check Form

Dear Sir or Madam:

Thank you for agreeing to be a reference for our volunteer. Please complete this entire form. Our volunteer must have at least two written references on file before they can provide service with our organization. This reference check form must be returned to the potential volunteer, addressed **Attn: Volunteer Coordinator, in a sealed (unopened) envelope with your signature written across the seal.** Your cooperation and quick response (within 1 week) is greatly appreciated.

Volunteer's Name: _____

Reference (Your) Name: _____ Title: _____

Organization/Affiliation: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Please answer the following questions:

How long have you known this individual? _____

What is your relationship to this individual? _____

In order to ensure the highest possible quality of care for our patients, please briefly describe any areas of concern that we should know about regarding this individual. _____

Would you recommend this individual for a volunteer position with our organization? _____

Additional comments can be written on the back.

Reference's Signature: _____ Date: _____

Please Rank these Questions: Unsatisfactory / Satisfactory / Excellent / Or Comment if Other

How would you rank this individual's quality of work? _____

How would you rank this individual's dependability? _____

What is/was this individual like to interact with as a co-worker?

Employee, associate or student? _____

How is/was this individual's involvement with clients/
patients/customers/others? _____

How would you rank this individual's leadership
capabilities? _____