SACRAMENTO COUNTY

Department of Health Services

MEDICAL VOLUNTEER/STUDENT INTERN APPLICATION

Name:	**Date:**
Address:	
City, State, Zip:	**Cell phone:**
E-mail address:	
Medical license number (if available):	**Type of license (R.N., M.D., etc.):** **Board Certificate:**
NPI number (if available):	**DEA number (if available):**
Medical Profession Affiliation:	
SPIRIT Affiliation : Yes ☐ No ☐	**Private Practice: Yes ☐ No ☐**
Medical Group:	
In case of emergency, please notify:	
Name: **Relationship:**	**Phone number:**

For applicant in Medical Training Program only:

Name of current or last medical school/college attended and clinical discipline/program:	**Education/Training Level:** ☐ **1st year** ☐ **2nd year** ☐ 3rd year ☐ 4th **year** ☐ 5th **year** ☐ **graduated** **Dept:**

Physician	**Nursing/ Ancillary**	**Pharmacy**	**Behavioral Health**
☐ **Faculty**	☐ **Nurse Practitioner**	☐ **Pharmacy Resident**	☐ **Psychiatry Resident**
☐ **Fellow**	☐ **R.N.**	☐ **Pharmacy Intern**	☐ **Psychiatry Student**
☐ **Resident**	☐ **Nursing student**		☐ **Ph.D.**
☐ **Student**	☐ **Medical Assistant**		**Others:**

Other medical training program not listed above:
Name of college administrative contact/coordinator: **Phone:**

Program assigned (check all that apply):	**Clinical Rotation Volunteer Position Start & End Date**	**Supervising Physician or staff**
Behavioral Health Programs		
☐ APSS		
☐ CAPS		
☐ SCMHTC		

Primary Health Programs		
☐ Juvenile Medical Services		
☐ Refugee Health Care		
☐ Sacramento County Health Center		
☐ Specialty Clinic		
Public Health Programs		
☐ Chest Clinic		
☐ Family-Nurse Partnership		
☐ Immunization Assistant Program (IAP)		
Other Clinic/Program:		
Senior & Adults Service Program		
☐ Public Health Nursing		
Duties to be performed by the medical resident/student/clinician/volunteer:		

As a medical volunteer/intern, I understand that I am not entitled for compensation for the services I provide. I agree to perform duties within my scope of business. I agree to follow County and program rules, procedures and protocols. I will strive to help the County obtain its goals and objectives and give my supervisor adequate notice before terminating my assignment.

Eligibility Requirements:

A. **Volunteer/intern applicant who does not have an active medical license will need to submit a criminal background check (live-scan) upon an offer of internship/rotation. Information obtained in the course of background check will be considered by the appointing authority in the selection process.**
B. **Must be able to show proof of authorization to work in the United States.**

Volunteer/Intern Signature: My signature affirms that all information on this application is true to the best of my knowledge and belief.

MEDICAL VOLUNTEER/STUDENT INTERN SIGNATURE **DATE**

RETURN THIS FORM WITH A COPY OF YOUR MEDICAL LICENSE TO THE ADDRESS BELOW

For official use only:

County Supervisor's Name:	**Phone:**	
Picture for ID Badge:	**DOJ/FBI Clearance Date:**	**Possible Placement:**

DHS Volunteer and Student Intern Services Office
7001A East Pkwy STE 1000, Sacramento, CA 95823
Phone: (916) 875-1250 Email: ThompsonJer@saccounty.net