

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):	
		Expiration Date:	
Medical Profession Affiliation:			
SPIRIT Affiliation: Yes <input type="checkbox"/> No <input type="checkbox"/>		Private Practice: Yes <input type="checkbox"/> No <input type="checkbox"/>	
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:	
		<input type="checkbox"/> 1 st year <input type="checkbox"/> 2 nd year <input type="checkbox"/> 3 rd year <input type="checkbox"/> 4 th year <input type="checkbox"/> 5 th year <input type="checkbox"/> graduated Dept:	
Physician	Nursing/ Ancillary	Pharmacy	Behavioral Health
<input type="checkbox"/> Faculty <input type="checkbox"/> Fellow <input type="checkbox"/> Resident <input type="checkbox"/> Student	<input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> R.N. <input type="checkbox"/> Nursing student <input type="checkbox"/> Medical Assistant	<input type="checkbox"/> Pharmacy Resident <input type="checkbox"/> Pharmacy Intern	<input type="checkbox"/> Psychiatry Resident <input type="checkbox"/> Psychiatry Student <input type="checkbox"/> Ph.D. 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			
<input type="checkbox"/> APSS			
<input type="checkbox"/> CAPS			
<input type="checkbox"/> SCMHTC			

Primary Health Programs		
<input type="checkbox"/> Juvenile Medical Services		
<input type="checkbox"/> Refugee Health Care		
<input type="checkbox"/> Sacramento County Health Center		
<input type="checkbox"/> Specialty Clinic		
Public Health Programs		
<input type="checkbox"/> Chest Clinic		
<input type="checkbox"/> Family-Nurse Partnership		
<input type="checkbox"/> Immunization Assistant Program (IAP)		
Other Clinic/Program:		
Senior & Adults Service Program		
<input type="checkbox"/> 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.

<p>Eligibility Requirements:</p> <p>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.</p> <p>B. Must be able to show proof of authorization to work in the United States.</p>
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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: