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 ☐ Medical Group:	Private Practice: Yes ☐ No ☐
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 ☐ Fellow ☐ Resident ☐ Student	☐ Nurse Practitioner ☐ R.N. ☐ Nursing student ☐ Medical Assistant	☐ Pharmacy Resident ☐ Pharmacy Intern	☐ Psychiatry Resident ☐ Psychiatry Student ☐ 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		
☐ 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