HealthWorks for Northern Virginia

163 Fort Evans Rd NE
Leesburg, VA 20176

1141 Elden St
Suite 300
Herndon, VA 20170

HealthWorks for Northern Virginia
A Community Health Center

Internal Use Only:
Immunization Record submitted _____ TB test submitted ____ Oriented ____ VA Risk _____

License Information confirmed by Volunteers Coordinator ____

Health Center Start Date: _____ Location: _____

MEDICAL POSITION VOLUNTEER APPLICATION

Name:_____
(Last) (First) (Middle)

Address:_____

City, State, Zip Code _____

Telephone: Primary ( )_____ **Secondary ( )**_____

Preferred E-mail Address: _____ _____

Employer: _____

If a student, school or university attending: _____

Languages Spoken:_____

How did you hear about Health Works _____

Availability: _____

Previous Experience and Skills: _____

_____

_____

_____

Do you have any medical conditions of which HealthWorks should be aware ?_____
_____

Person to contact in event of emergency:

Name_____Relationship_____

Day phone #_____Cell phone #_____Evening phone#_____

Volunteer Position Desired: [ ] Provider [ ] Nurse [ ] Phlebotomist

Other: _____

Volunteer Location Desired: Herndon HealthWorks Center [ ] Leesburg HealthWorks Center [ ]

Medical/Licensed Volunteers

Physician:

License # _____ **Medical Specialty** _____

Exp Date _____

Location and Date of residency program(s):_____

Specialty of residency program(s):_____

Nurse Practitioner:

License # _____ **Exp Date** _____

Physician Assistant:

License # _____ **Exp Date** _____

Registered Nurse/Allied Health Professional:

License # _____ **Medical Specialty** _____

Exp Date _____

References:

Please provide three references, at least one of which is professional.

Name: _____

Relationship/context in which you know reference: _____

Preferred contact information:_____

Name: _____

Relationship/context in which you know reference: _____

Preferred contact information:_____

Name: _____

Relationship/context in which you know reference: _____

Preferred contact information:_____

License will be reported to the Commonwealth of Virginia Division of Risk Management to activate state malpractice protection.

I agree that all the information above is correct to the best of my knowledge.

Signed: _____ Date: _____