



**VOLUNTEER INFORMATION**  
**APPLICATION PHYSICIANS,**  
**PHARMACISTS AND NURSES**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Specialty: \_\_\_\_\_

Place of Business: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**YOUR BACKGROUND**

Affiliations:  
\_\_\_\_\_

Charitable or community activities in which you have been involved in:  
\_\_\_\_\_

**YOUR AVAILABILITY TO SERVE**

Would you be interested in serving on our Board of Directors? \_\_\_ Yes \_\_\_ No

Do you have any conflicts of interest? \_\_\_\_\_

Would you be able to attend board meetings? \_\_\_\_\_ Yes \_\_\_\_\_ No

How many hours a month could you serve the Lorain County Free Clinic? \_\_\_\_\_

What days and times would you be available?  
\_\_\_\_\_