

Please complete this form and attach any necessary documentation and return to the following:

Delise Webb
Good Samaritan Health Center
1015 Donald Lee Hollowell Parkway
Atlanta, GA 30318

Phone 678-553-4904
Fax 404-523-6574
delise@goodsamatlanta.org
www.goodsamatlanta.org

VOLUNTEER APPLICATION

Name _____ Date _____

Spouse's name _____ Birthday _____

Home address _____

City, State, and Zip _____ Email _____

Home phone _____ Cell phone _____

Race: Caucasian African American Hispanic/Latino Asian Native American Other

Occupation _____

Name of employer _____

Employer address _____

City, State, and Zip _____ Phone _____

Church or congregation _____

Are you a professional licensed in the state of Georgia? _____

If so, please answer following questions:

Professional license number _____

Please attach a copy of your professional license, front and back.

Malpractice carrier (if applicable) _____

Please attach a copy of your coverage page.

Do you speak a foreign language? If so, please indicate language. _____

Special skills or hobbies _____

FOR GSHC USE ONLY:	Approved By _____	Start Date _____
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Present or previous volunteer experience _____

How often would you like to volunteer and in what area? _____

Please indicate preferred days and times. _____

How did you hear about the Good Samaritan Health Center? _____

What interests you about volunteering here at the Center? _____

Are you completing these volunteer hours for school or other community requirement? _____

If so, please complete the following questions:

School _____

Area of study and year _____

Requirements of volunteer experience (necessary hours, duties, etc.) _____

Supervisor's name, title, and phone number _____

Please attach any necessary paperwork.

Is there anything else that you would like for us to know about you? _____
