

MCCP Volunteer Form



Full Name: _____

Email Address: _____

Cell: _____ Home: _____ Work: _____

Occupation: _____

If you are a Student: School name _____ Grade or year in higher ed: _____

Home Address: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship: _____

Any health issues we should know about?:

How did you hear about our program?:

Possible Availability for volunteer events (day and times):

Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

For High School Students:

How did you hear about our program and why would you like to volunteer?

I understand my son/daughter will be volunteering in a medical/dental setting, and safety of patients, staff and volunteers is of highest priority. In addition patient privacy is mandatory.

Parent name: _____

Parent Signature: _____

For ALL volunteers:

I understand that we are in a professional setting, and all private medical/dental and personal information (names, phone numbers, addresses) that is gathered or discussed during MCCP events will not be discussed outside of our clinic or event. Our patients' privacy must be maintained and any questions or concerns must be directed to Dr. Susan Kohn (Medical/Dental Community Outreach Coordinator) or Marcia Twomey (Executive Director) so they can be addressed.

Name (printed): _____

Signature: _____