



Dear Prospective Nurse Volunteer,

In addition to the online Volunteer Application that all volunteers complete we ask that licensed nurses provide additional credentialing information. Please send copies of the following items by email/fax/mail to the clinic:

1. Driver's license/passport
2. Nursing license and if available, CPR certification
3. TB skin test within 1 year (or chest x-ray within 5 years)
4. Resume

In addition, please complete and send the forms found on the following pages:

1. "Volunteer Reference Release Form"
2. "Communicable Disease Statement"

Nurses can volunteer in several critical capacities at Clinic by the Bay. For those nurses interested in providing direct patient care during medical visit hours we ask for the following time commitment:

- Complete three 4-hour training shifts in the first two weeks of volunteering
- Volunteer for one 4-hour shift every two weeks for the first 3 months.

Thank you for interest in volunteering with Clinic by the Bay and all of your efforts in bringing our vision to life. We look forward to working with you.

Regards,

Karen Fenton, RN
Clinic Manager
karen@clinicbythebay.org



San Francisco's Volunteers in Medicine Clinic
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Volunteer Reference Release Form

At least one reference must be from a current/former supervisor. Remaining references can be professional or personal.

I give permission for the below named individuals and/or agencies to release information to Clinic by the Bay concerning my character, employment, performance, skills, competence, and/or general ability.

It is understood that this permission includes cumulative and confidential information, which would assist Clinic by the Bay in filling volunteer positions.

Name	Email Address	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I am interested in the following volunteer positions (If more than one, please list in order of most desired.)

1. _____
2. _____
3. _____

NAME

SIGNATURE

DATE

Communicable Disease Statement for Direct Patient Care Volunteers

CONFIDENTIAL

I am informed and believe, to the best of my knowledge, that I do not have any contagious disease or other health condition posing a risk of transmission to patients, staff or other volunteers.

OR:

My Hepatitis B and TB status is as follows (PPD or CXR within last year):

Volunteer name: _____

Role(s): _____

Date: _____