5750 Pineland Dr Suite #300
Dallas, Texas 75231
Phone: 214.221.0855, Ext. 2001
Fax: 214-221-1437

CONTACT INFORMATION

Name:______________________________________
Home Phone:____________________________________
Social Security #:________________Date of Birth: _______________
Home Address: __________________________________
____
Employer:_____________________________________
Work Phone: ____________Work Address: ______________________
Cell:_____________________ Msg. Phone: ________________
E-mail address: __________________________________
How would you prefer to be contacted? ________________________

EDUCATION AND EXPERIENCE

Administrative Experience: ______________________________
Degree/Training: ___________________________________
Nursing/Tech/Hygiene School: ____________________________
Degree: _______________________________________
Medical School: ___________________________________
Dental School: ____________________________________
Degree: _______________________________________

LICENSURE, CERTIFICATION, AND PRIVILEGES

Texas Medical License #:_______________________________
Texas Dental License #: _______________________________
UPIN # (if applicable): _______________________________
DEA # (if applicable): ________________________________
NPI #: (if applicable): _______________________________
DPS#: (if applicable): _______________________________

Have you ever been convicted of a felony? Yes No
If yes, please explain: ________________________________
____
____

CIRCLE ONE:

What days of the week can you volunteer?

Monday Tuesday Wednesday Thursday Friday Saturday

How many days a month can you volunteer? Daytime or evening?

1 2 3 4 5

How did you hear about Healing Hands Ministries?________________________________

____

Do you speak Spanish or another language?_____________________________________

Any special skills?____

____

Church affiliation____

APPLICANT'S STATEMENT

Read the following carefully, then sign and date the application.

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for volunteer service as may be necessary in arriving at a decision. In the event of acceptance as a volunteer at Healing Hands Ministries Inc., I understand that false or misleading information given in my application or interview may result in discharge. I understand, also, that I am required to abide by all policies and procedures of Healing Hands Ministries Inc.

I read and I understand the Confidentiality Policy of Healing Hands Ministries Inc.
I agree to comply with the policy and procedures set forth protecting the confidentiality of clients, staff, students, and volunteers. I understand that deliberate violation of this acknowledgement will result in immediate dismissal.

Signed: ____

Date: ____

*Licensed medical and dental volunteers, please include a photocopy of your current license with application.