



# St. Anna's Medical Mission



## OUT-OF-STATE VOLUNTEER INTAKE FORM (PLEASE PRINT CLEARLY)

**Volunteer Name:** \_\_\_\_\_  
(first) (middle) (last)

**Are You a:** \_\_\_MD \_\_\_Nurse Practitioner \_\_\_RN \_\_\_Spiritual Counselor \_\_\_EMT/Med Tech \_\_\_Non-medical

**Address** \_\_\_\_\_  
(street) (city) (state) (zip)

**Phone:** (\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
(day) (evening) (cell)-to be used in N.O.)

**Email Address:** \_\_\_\_\_ **Fax No.** \_\_\_\_\_

**IF YOU ARE COMING WITH A GROUP:**

**Group Leader Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Group Leader Phone: (home/office)** \_\_\_\_\_ **(cell used in N.O.)** \_\_\_\_\_

**Church/Organization/Group Name:** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_

**Clergy Name (if church group):** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_

**Arriving by:** Car Van Bus Plane Train RV/Trailer Other: \_\_\_\_\_  
\*\*If not arriving by car/van, it is your responsibility to secure your own transportation while here.

**Arrival Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **am/pm** **Departure Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **am/pm**

**Dates Requesting to Volunteer:** \_\_\_\_\_

**Housing Needed?** YES NO, **If NO, where will you be staying?** \_\_\_\_\_

**EMERGENCY CONTACT #1:** **Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(first) (last) (with area code)

**EMERGENCY CONTACT #2:** **Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(first) (last) (with area code)

**YOUR PHYSICIAN:** **Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(with area code)

**MEDICAL CONDITION:** List any medical conditions you have (asthma, diabetes, epilepsy, etc.): \_\_\_\_\_

List any allergies or allergic reactions to medications: \_\_\_\_\_

List any medications you are currently taking (continue on back): \_\_\_\_\_

**Date of last Tetanus shot:** \_\_\_\_\_ **Have you had a complete Hepatitis B Vaccination Series?** YES NO\*\*  
\*\*If NO, I understand that the lack of the vaccine and contact with potentially infected blood and body fluids will place me at higher risk for contracting Hepatitis B \_\_\_\_\_(initials)

Other pertinent medical information: \_\_\_\_\_

**MEDICAL INSURANCE: (Attach and bring a copy of your healthcare and pharmacy card with you!!)**

Company \_\_\_\_\_ Policy No. \_\_\_\_\_ Claims Phone # \_\_\_\_\_