DIVINE HEALING
MINISTRIES
OF GEORGIA

Dear Volunteer Applicant,

Thank you for your interest in volunteering at Divine Healing Ministries of GA. You have chosen to be part of a dynamic team of volunteers who enhance the patient experience at our community health and social services center. Please download the volunteer application and ensure that the following sections are complete. In an effort to ensure the application review process is timely, please note that incomplete applications will be returned to the applicant. Please make a copy of your application for your records prior to submitting.

Adult Applicants (over the age of 18)

_____ Application
_____ 2 Professional References
_____ Doctor's Release Form
_____ Background Check Form (completed at interview)

Please send completed applications to:

Volunteer Services Dept.
Divine Healing Ministries of GA
PO Box 2856
Acworth, GA 30102

Upon receipt of your completed application, you will be contacted to discuss the exciting volunteer opportunities at Divine Healing Ministries of GA. Please note that we ask for a minimum commitment of 150 hours annually with a minimum commitment of one year of service.

Every new volunteer is required to attend a New Volunteer Orientation. It is a five-hour educational session covering such topics as safety, infection control and patient confidentiality.

If you have any questions about the volunteer application process, please feel free to contact Dr. Marcus Bakkar, DC or Linda Jones at the Volunteer Services Department at 470-264-0572 or e-mail us at divhealingmin@gmail.com

Sincerely,

Dr. Shatillia McFarlin-Ball, MBAHCM, DC
Founder/CEO

Divine Healing Ministries of GA
Volunteer Services
PO Box 2856
Acworth, GA 30102
Telephone: 470-264-0572 Fax: 678-623-5728

Adult Volunteer Application

(This application will be kept confidential) Date _____

Personal Contact Information:

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____

Birth date _____ Gender _____ _____
Month/Day/Year female male

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

In what area(s) are you interested in volunteering? #1 _____ #2_____

What day(s) and hours are you available to volunteer?

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

We ask for a minimum commitment of 150 hours annually with a minimum commitment of one year of service.

General Information:

How did you learn about our program? _____

Why are you interested in volunteering for Divine Healing Ministries of GA? _____

_____

Work Experience:

Name of Employer: _____ Date(s): _____

Business Address: _____ Phone: _____

Volunteer Experience:

Name of Organization: _____ Date(s): _____

Business Address: _____ Phone: _____

Hobbies, interests, or skills: _____

_____

Languages: English ____ Speak ____ Read ____Write
Spanish/Other _____ ____ Speak ____ Read ____ Write

Academic Background:

High School: _____ Years Completed: _____

College: _____ Years Completed: _____

Other Educational Experiences: _____

Are you interested in a health career? Yes ____ No ____ If yes, which area?

_____

We appreciate your interest in our hospital. A clear understanding of your background and work history will assist us in considering you for the volunteer position that best meets your qualifications and interests.

Interests and Skills (Please indicate with a checkmark)

Clerical Skills:

___Typing
___ Filing
___ Phone Receptionist
___ Using Copier
___ Mailings
___ Alphabetizing
___ Cash Register
___ Other (specify) _____

Patient Care Services:

___ Chiropractic Services
___ Medical Services
___ Pastoral Care
___ Mental Health Services
___ Legal Assistance
___ Other (specify) _____

Additional Skills/Comments: _____

The Divine Healing Ministries of GA Volunteer Program is available to all, without regard to race, color, national origin, disability, gender, political affiliation, or religion.

Professional references: Even though you have given the attached Professional Reference Check forms to your two references to complete, please write their names, addresses and phone numbers below in case more information is needed. References should not be immediate family members. **Your application is not complete if any reference information is omitted.**

1. _____
   Name Phone

   _____
   Address City State Zip

2. _____
   Name Phone

   _____
   Address City State Zip

Have you ever been convicted of a crime? Yes ____ No ____. If yes, please explain the nature of the crime, when and where it occurred, and the outcome.

_____

_____

_____

The information provided is accurate and correct to the best of my knowledge. My signature indicates that I give my approval and permission for Divine Healing Ministries of GA to check my references; that I understand I will not be compensated for my services; and that I understand that the Volunteer Services Dept. is not obligated to provide a placement, nor am I obligated to accept the position offered; and my signature indicates that if an assignment is accepted, I agree to abide by all Divine Healing Ministries of GA rules and regulations as outlined in the New Volunteer Orientation.

I am able to volunteer a minimum of 150 hours annually and am committed to volunteering a minimum of one year at Divine Healing Ministries of GA.

Signature _____ Date _____

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Interviewer _____ Date _____ Time _____

Assignment _____ Day(s) _____ Time(s) _____

Department of Volunteer Services
Professional Reference Check

I, _____, have applied for a position as a volunteer with Divine Healing Ministries of GA. Please take a moment to complete this form or write a letter of recommendation on my behalf. Upon completion, please return it to me in a sealed envelope. You may be contacted by the Volunteer Services Dept. for more information or to verify authenticity.

1. What is your relationship to this applicant? _____
2. How long have you known him/her? _____
3. How would you describe his/her general attitude? _____
4. Is he/she dependable? _____ Responsible? _____
5. How would you describe his/her interpersonal skills? _____
6. What is his/her greatest attribute? _____
7. Any additional comments that you would like to make regarding this candidate? _____

Print name: _____ Signature: _____

Date: _____ Telephone Number: _____

If you have any questions, please contact Dr. Marcus Bakkar, DC or Linda Jones at 470-264-0572.

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Divine Healing Ministries of GA

Medical Clearance Form - New VOLUNTEER Applicant.

Volunteer Name:_____ DOB: _____

Volunteer applicant Assignment (if known):_____

_____ NOT medically cleared to Volunteer in Divine Healing of Ministries of GA clinic locations.

_____ YES medically cleared to Volunteer in Divine Healing of Ministries of GA clinic locations.

_____ YES medically cleared to Volunteer in Divine Healing of Ministries of GA clinic locations with the following Restrictions/Limitation: _____

_____

_____

_____ _____

Nurse Practitioner/Physician (NP/MD/DO/DC) Date