



Westminster **Free Clinic**

Please complete the application and attach a resume and copy of your professional license. This information will be kept in a locked, confidential file. Thank you.

How did you find out about the Clinic? _____ Date: _____

Name: _____ Birthdate (day & month) _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____ Fax: _____

Cell: _____ Pager (emergencies only): _____

E-Mail address: _____

Signature: _____

Professional Occupation: _____

License #: _____ Exp. Date: _____

DEA #: _____ Exp. Date: _____

Do you have a specialty? _____

Services you are interested in providing: _____

Other languages you speak fluently: _____

Days and times you are available for Clinic assignment (if applicable):

Days: _____ On Call: _____

Evenings: _____ Once per month: _____

Weekends: _____ Twice per month: _____

Please list any skills that you are willing to share on behalf of the Clinic:

Please list any other organizations with which you are affiliated:
