



COMPLEMENTARY CLINIC

610 16th Street Oakland, CA 94612 • Ph: 510 601-7660 ext 20 • Fax: 510 601-7669

# CMCC VOLUNTEER APPLICATION

Today's Date: \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Are you bilingual? Yes No If yes, what language(s)? \_\_\_\_\_

Are you comfortable speaking fluently in your Modality? Yes No

## PLEASE CHECK THE MODALITY / SERVICE(S) YOU WOULD LIKE TO PROVIDE AT CMCC:

- Interpreter** Spanish  Mandarin  Cantonese
- Driver** Can you drive to East Bay San Francisco Berkeley/Oakland Only
- Support Staff** Interested in Events Outreach Fundraising Mailings Office Work PR

**Support Staff & Interpreter roles are limited in San Francisco at this time-**

**You will be notified of the specific openings.**

- Acupuncture** How many rooms can you handle at once? 1 2 3 4 5 Rooms. License # \_\_\_\_\_
- Massage** Swedish Shiatsu (acupressure) Reiki Rosen Craniosacral therapy Other \_\_\_\_\_
- Therapeutic Imagery**  **Western Herbs**  **Chinese Herbs**
- Homeopathy**  **In-Home Care**

Please list your experience, schooling and/or years in practice for the modality type(s) you checked above. For drivers, please list your car type, license # and current insurance policy; for massage therapists, please list your number of training hours, and if you are a CMT.

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\_\_\_\_\_  
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## VOLUNTEER SHIFT REQUEST

*New volunteers are asked to make a one-year commitment to serve on at least one, four-hour shift per month and are encouraged to attend modality meetings. Fridays in Oakland have limited openings for practitioners.*

**Two shift times are available: Morning 9:30am-1:30pm and Afternoon 1:30pm-5:30pm.**

**Two clinic locations are available: Oakland or San Francisco.**

**Clinic location desired:** Oakland ( Fri, Sat or Sun) San Francisco (Fridays & Saturdays Only)  
Either Oak or SF

## PERSONAL INFORMATION

Are you presently working and/or studying? Full Time Part Time

What is your occupation or course of study? \_\_\_\_\_

Do you have any allergies? Yes No If yes, briefly describe: \_\_\_\_\_

Have you had any major life illnesses or changes in the last 12 months? (Please describe.)

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Have you ever had cancer? Yes No If yes, what kind? \_\_\_\_\_

Has anyone close to you had cancer? Yes No Died from cancer? Yes No

Comments: \_\_\_\_\_

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Have you recently experienced a loss through death? Yes No If so, please briefly describe:

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Have you spent time with someone very sick and/or dying? Yes No If so, please briefly describe:

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How did you hear about CMCC? Flyer Newspaper Internet (list website)\_\_\_\_\_ Friend Other

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Have you ever applied to be a CMCC volunteer in the past? Yes No If yes, when? \_\_\_\_\_

Have you done any volunteer work before? Yes No If yes, where and what kind?

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**Tell us why you want to be a CMCC volunteer.** Please respond to the following questions as thoughtfully and completely as you can, exploring your feelings and intentions. Be certain to cover all the points indicated. Please feel free to write on the back if you need more room.

1. How do you see your role as a CMCC volunteer? \_\_\_\_\_

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2. It is important for caregivers to have strong emotional support in their own lives. What sources of emotional support do you have available to you? \_\_\_\_\_

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3. How do you feel about the time and energy required to volunteer for CMCC? \_\_\_\_\_

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4. Do you anticipate anything which may interfere with fulfilling the one-year commitment to CMCC, e.g., family obligations, possible plans for relocation, future study? **CMCC has determined that the cost of recruiting & training new volunteers who do not stay a full year is prohibitive. Please consider this carefully before attending our free 2 day training and joining our staff of volunteer providers.**

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5. Any additional thoughts that come up for you in completing this application, or is there anything else you would like us to know? \_\_\_\_\_

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**Please list 2 professional references for us to contact, including the full name and phone number:**

1. \_\_\_\_\_

2. \_\_\_\_\_

**Please enclose a recent copy of your resume if you have one, and if you are a body worker, please include a copy of your CMT certification.**

**Thank you for considering volunteering at The Charlotte Maxwell Complementary Clinic!** We appreciate the time and thought involved in completing this application. If you have any questions, please contact the Volunteer Services Department at: 510 601-7660 ext. 20

FOR OFFICE USE ONLY

Date received: \_\_\_\_\_ Date of interview: \_\_\_\_\_ Date of training: \_\_\_\_\_ Date of C.O. shift: \_\_\_\_\_

Intake and placement complete (staff initials and date): \_\_\_\_\_