

OFFICE USE ONLY	
Date application received	_____
Applicant Placed	Yes _____ No _____
Preceptor	_____
Start Date	_____
Signature	_____

Volunteer and Learner Request Form

First Name _____ Last Name _____

Address _____

Email _____

Telephone (Home) _____ Telephone (Cell) _____

Emergency Contact Name _____ Relationship _____

Telephone (Home) _____ Telephone (Cell) _____

Type of Request

- Student affiliated with an academic institution (e.g. completing a placement)
- Medical Resident
- Medical Fellow
- Volunteer (minimum of 3 months commitment)
- Clinical Observer (i.e. observation in patient care)

Please fill out the following academic information, if applicable:

Educational Institution _____

Program of Study _____

Degree/Diploma _____

Year of Study _____ Expected Date of Completion _____

Academic Contact _____

Telephone _____ Email _____

Experience Start Date _____ Experience End Date _____

Number of Hours Required _____

Days of the week you are available for the experience					
Days	Monday	Tuesday	Wednesday	Thursday	Friday
Times (indicate the times that you are available on each day)					

What are your learning objectives/goals and interests?

What are your relevant experiences related to this request?

Once completed, please **email this form and your resume** to info@boomeranghealth.com. Please indicate in the subject heading the **type of experience** that you are seeking.