Surgery on Sunday, Inc.
Helping Those In Need

Volunteer Form

(Doctor and or Nurse)

Last Name:______________________________________ First Name:__________________________________

Address: ____

____

____

Phone Number:______________________________ Pager/Cell:_________________________

E-Mail: _____________________________________ Fax:_______________________________

License:_____________________________________ No./SS:_____________________________

Employment Site/Privileges:____________________________ DOB:______________

Specialty:____

____

Credentialing Health Center:____

Area of Volunteer/Interest:____

Bilingual:_____________________________ Computer Skills:____________________

**PLEASE ENCLOSE A COPY OF YOUR LISCENSE.

RELEASE OF INFORMATION/AUTHORIZATION

I _____________________________________hereby give Surgery On Sunday, Inc. permission to receive information/documents from my employer/hospital____, concerning my occupational license and credentialing data for their use only.

____
APPLICANT

____
Witness Date

*Please fill out form completely and return to the fax number listed below. If you have any questions please feel free to contact us via phone or email listed below.

650 Newtown Pike (2nd Floor), Lexington, Ky. 40508 | Phone: 1-859-246-0046 | Fax: 1-859-246-1752 | Web: www. suregeryonsunday.org