Student and Volunteer Application

ADVANCED therapy SOLUTIONS
serving children and their families Kids!

Contact Information	
Name	
Mailing address City, State Zip code	
Email Address	
Phone Number	Home
	Cell
How did you hear about ATS?	

Education Information		
Are you ***currently*** in school?	Yes	No
If so, where do you attend?		
What is your ***current or intended*** area of study?		
Is this application specifically for a **school CLINICAL rotation?**	Yes	No
Is this application specifically for a **school class internship?**	Yes	No
If not in school, where are you ***currently*** employed?		

Area of Intended Focus			
What therapy area are you interested in?	OT	PT	Both/Undecided.
Have you completed any shadowing/volunteering for this therapy before? (Any location) If yes, please state where and what area (ie adult orthopedics; pediatric hospital)	Yes:		
	No, this is my first experience.		

Availability *We strive to coordinate opportunities for both clinical students and volunteers. Let usreview your application to better understand your request.					
Which is your clinical preference?	Spartanburg			Greenville	
What is your PREFERRED date range?					
Do you need to complete ALL LISTED hours in one location?					
How many hours are you interested in?	Total:				
	Per week:				
	Mon.	Tues.	Weds.	Thurs.	Fri.
What mornings are you available?					
What afternoons are you available?					

Special Skills or Qualifications
Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

Previous Volunteer Experiences
Summarize any previous volunteer experience.

Emergency Contact Information	
Name	
Mailing address City, State Zip code	
Email Address	
Phone Number	Home
	Work
	Cell
Relation	

Agreement and Signature	
By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal. **Furthermore, if I am accepted as a volunteer, I acknowledge that during my volunteer experience I may be asked to complete clinic based projects. I will actively assist therapists as requested and take independent initiative to ask how I can assist therapists and staff. I acknowledge I will keep log of my own clinical experience hours and sign in and out per day. I will also actively follow medical patient privacy, and sign a HIPPA form upon my first day.**	
Name (Printed)	
Signature	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in volunteering with us.

You can submit your application by **fax, email or mail** to either of the clinics listed below:

Spartanburg Pediatrics
2400 Winchester Place, Suite 102
Spartanburg, SC 29301 FAX: (864) 576-8909
blaire@advancedtherapysolutions.com

Greenville Pediatrics at Haywood
28 Jimmy Doolittle Drive
Greenville, SC 29607 FAX: (864) 679-8608
lisaroehl@advancedtherapysolutions.com