



Volunteer Involvement Form for Optometrists

136 W Peoria Street, Pasadena, CA 91103
 phone: 626.795.5166 • fax: 626.795.8154

Optometrist's Information:

Name: _____
First Middle Last

Today's Date: ____/____/____ Birthday: (Month/Day): ____/____

Group Name or other partners at same location: _____

License Number: _____

Professional Liability Insurance Carrier: _____

Please attach a copy of your Certificate of Liability Insurance.

Office Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: (____) _____ Office Fax: (____) _____

E-mail Address: _____

When we call your office, to whom should we ask to speak? _____

Do you have bilingual capabilities in your office? yes no Language(s): _____

Do you accept: MediCal Covered California

May we use your name in Young & Healthy publications? yes no

Do you have colleagues who you believe would be interested in learning more about Young & Healthy?
 (name & contact info) _____

Specific times & days of the week that you are available:

AM Monday Tuesday Wednesday Thursday Friday

PM Monday Tuesday Wednesday Thursday Friday

Continued on reverse side →

Treatment Component:

I am willing to participate in the following Young & Healthy treatment programs (check all that apply):

- I will provide _____ free primary vision examination(s) per month.
- I would be happy to provide care for emancipated foster youth (ages 18-25).
- I would be interested in helping with vision screenings at a school site.
- Other: _____

(please specify)

Education Component:

I am willing to give group lectures or participate in small group discussions with parents in the community to help them better deal with their children's visual needs. I would be willing to lead a session on the following topic(s):

Others on my staff who would be interested in participating in educational programs: _____

Education Schedule Availability (check & circle all that apply)

- | | | | | | |
|---------------------------------|----------------------------------|------------------------------------|-----------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Monday | <input type="checkbox"/> Tuesday | <input type="checkbox"/> Wednesday | <input type="checkbox"/> Thursday | <input type="checkbox"/> Friday | <input type="checkbox"/> Saturday |
| AM/PM/Eve | AM/PM/Eve | AM/PM/Eve | AM/PM/Eve | AM/PM/Eve | AM/PM/Eve |

Is there anything else that you would like us to know about your practice?

As part of my professional response to the need for health care of large numbers of under and uninsured children in the Pasadena community, I am volunteering the services I have checked above for children identified by Young & Healthy.

Optometrist's Signature: _____ Date: _____

For Office Use: Ltr. Sent: _____ VT: _____ Ref. Pg.: _____ Access: _____
RP: _____ Lic.: _____ Ins.: _____