

ANNUAL VOLUNTEER DEMOGRAPHICS

VOLUNTARY HEALTH CARE PROGRAM PROVIDER

ADMINISTRATIVE SERVICES UNIT
 UNIVERSITY PARK PLAZA
 2829 UNIVERSITY AVENUE SE, SUITE 445
 MINNEAPOLIS, MINNESOTA 55414
 651-201-2732 or www.asu.state.mn.us

Name of Facility or Organization _____
ANNUAL VOLUNTEER DEMOGRAPHICS
 To be completed for renewal of facility / organization registration

REQUIRED INFORMATION	HEALTH CARE REGISTRATION RESPONSE
This is due August 31 st or with application / renewal form Begin & End dates data is provided _____ to _____	

Number of Volunteers: (Total for organization) _____	Number of Volunteer Hours: (Total for organization) _____	Number of Patients Seen: (Total for organization) _____
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What is the minimum number of hours you require each volunteer to provide each month? _____
 If you do not have a minimum, what do you consider the optimum to be? _____

Information below is per individual volunteer provider registered in the Health Care Provider Program (2 per sheet)

Volunteer Provider Name: (Individuals in program only)	Name: _____ Dates of Service: _____ to _____	Name: _____ Dates of Service: _____ to _____
Number of Volunteer Hours:	Week: _____ Month: _____ Year: _____	Week: _____ Month: _____ Year: _____
Number of Patients seen by volunteer providers:		
Types of services provided:		
Additional Comments		