

**VOLUNTEER APPLICATION**

Full name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ email \_\_\_\_\_

Best time &amp; number to call you \_\_\_\_\_

Ethnic or cultural background:

White \_\_ Black \_\_ Asian \_\_ Hispanic \_\_ Native American \_\_ Other \_\_\_\_\_

Languages \_\_\_\_\_ Sign language yes \_\_ no \_\_

Date of birth: \_\_\_\_\_

Sex: M F

In case of an emergency we should contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Special interests, hobbies, skills:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of volunteer opportunities (check all that interest you):

- |   |  |
|---|--|
| <input type="checkbox"/> In Home Respite                | <input type="checkbox"/> Time Off for Caregivers (2 <sup>nd</sup> & 4 <sup>th</sup> Saturdays) |
| <input type="checkbox"/> Convalescent Hospital Visiting | <input type="checkbox"/> Office work   |
| <input type="checkbox"/> Pet Visiting                   | <input type="checkbox"/> Special Events (e.g., Winter Concert, Beer Fest)                      |
| <input type="checkbox"/> Pen Friend                     |  |

Time availability (circle the possibilities):

Morning	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Afternoon	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Evening	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

**Citizens Who Care**

\*1260 Lake Blvd. #208, Davis, CA 95616\*Tel (530) 758-3704\*Fax (530) 758-3773\*

Email: [citizenswhocare@omsoft.com](mailto:citizenswhocare@omsoft.com)

Education:

School	State	Major	Degree	Dates
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Employment:

Employer	Address	Position	Dates
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Personal References (Two are required):

Name	Address	Phone
(1)		
(2)		

Please describe your prior volunteer and/or work experience:

\_\_\_\_\_

Have you ever been convicted of a felony?  Yes  No If yes, please state the crime for which you were convicted.

\_\_\_\_\_

How did you learn about CWC? \_\_\_\_\_

Why did you decide to volunteer with CWC at this time? What would you like to get out of the experience?

\_\_\_\_\_

Do you have any health problems or impairments that affect your ability to volunteer for CWC or for which special accommodations should be made?  Yes  No If yes, please explain

\_\_\_\_\_

I hereby authorize Citizens Who Care to conduct a review of all public information about me to assure client safety. In this regard, I understand that Citizens Who Care may terminate or adjust my services at anytime.

Signature \_\_\_\_\_

Photo identification (state type of I.D.) \_\_\_\_\_

Staff initial (verifies photo I.D.) \_\_\_\_\_

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**Convalescent hospital visitor and in-home respite volunteer applicants  
should also fill out this page**

Name \_\_\_\_\_

Briefly describe your experience with the elderly or the disabled.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Program preference \_\_\_\_\_ No preference \_\_\_\_\_  
    \_\_\_ In-home respite  
    \_\_\_ Convalescent hospital (facility you prefer \_\_\_\_\_)

Indicate whether or not you would be willing to be assigned to a patient who:

	<u>Yes</u>	<u>No</u>
Is physically handicapped	___	___
Is non-ambulatory or bedridden	___	___
Has controlled seizures	___	___
Is vision-impaired or blind	___	___
Is hearing-impaired or deaf	___	___
Cannot speak or has difficulty speaking	___	___
Is incontinent (urine or feces)	___	___
Has dementia	___	___
Is depressed or withdrawn	___	___
Is confused or disoriented	___	___

What is your usual mode of transportation?  
    \_\_\_ walking \_\_\_ bike \_\_\_ car \_\_\_ bus

Do you smoke? \_\_\_ yes \_\_\_ no

Have you any preferences or special conditions that should be considered in assigning you? (e.g. allergies, fear of pets, desire to bring a child along)

\_\_\_\_\_  
\_\_\_\_\_

CWC office use:

Date training completed \_\_\_\_\_ Date assigned \_\_\_\_\_

Forwarded to \_\_\_\_\_ on \_\_\_\_\_

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