CROSAIRES

"Where Care and Community Intersect"

VOLUNTEER APPLICATION

Vision:

Honoring elderhood by continuously creating a culture of well-being rich in meaning and purpose.

PERSONAL INFORMATION

DATE: _____

NAME_____

FIRST M LAST

SOCIAL SECURITY NUMBER _____

PRESENT ADDRESS_____

Street CITY STATE ZIP CODE

PERMANENT ADDRESS_____

Street CITY STATE ZIP CODE

PHONE NO: _____ **Email Address: _____**

VOLUNTEER OPPORTUNITIES DESIRED

Days of the Week: M T W TH FRI SAT SUN

Times Available: _____

HAVE YOU EVER VOLUNTEERED AT CROSAIRES BEFORE? YES _____ NO _____ WHEN _____

REFERRED BY: _____

SPECIAL SKILLS OR INTERESTS:

_____
_____
_____
_____
_____

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES _____ NO _____ IF YES, PLEASE DESCRIBE BELOW:

_____
_____

- **This form has been revised to comply with the provisions of the Americans with Disabilities Act and the final regulations and interpretive guidelines promulgated by the EEDC on July 26, 1991**

REFERENCES: Give the names of three (3) persons who are not related to you and have known you for at least one year.

	Name	Address	Phone Number	Years Known
1.				
2.				
3.				

IN CASE OF AN EMERGENCY NOTIFY:

NAME: _____

ADDRESS: _____

PHONE #: _____

"I certify that all of the information submitted by me on this application is true and complete, and I understand that if any false information, omissions, or misinterpretations are discovered, my application may be rejected and, if I am chosen to volunteer I know this may be terminated at any time. In consideration of my volunteerism, I agree to conform to the company's rules.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

Note: All Volunteers must be cleared criminally, medically and have a negative TB test before beginning volunteering

Feb 2012