VA-1

CITIZENS WHO CARE VOLUNTEER APPLICATION

Your full name:
____Date__________

Address: ____

Telephone: Home________________ Work _______________ Cell__________________

E-mail: ____

Best time & number to call you: ____

Ethnic or cultural background:
White Black Asian Hispanic Native American
Other____________________________________

Languages: ____________________________________ **Sign language:** Yes No

Date of birth: _________________ **Gender:** 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):
In Home Respite
Pen Friend
Convalescent Hospital Visiting
Office work
Pet Visiting
Special Events (e.g., Winter Concert, BeerFest)
Time Off for Caregivers (2nd & 4th Saturdays/Davis Sr. Ctr.)

Time availability (check 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 for the Elderly
• 409 Lincoln Ave., Woodland, CA 95695 • Tel (530) 758-3704 • Fax (530) 668-8788 •
Email: cwcvc@.dcn.org

Education:

School	State	Major	Degree	Dates

Employment:

Employer	Address	Position	Dates

Personal/Character References *(Two individuals NOT related to you are required):*

Name	Address	Phone	How do you know?
(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. (Electronic submission of this form with name typed below will substitute for signature consent.)

Signature ____

Convalescent hospital visitor and in-home respite volunteer applicants must also fill out this page.

Name: ____

Briefly describe your experience with the elderly or the disabled.

Program preference:

No preference
In-home respite & friendly visiting
Convalescent hospital (facility you prefer ______________________________)

Indicate whether or not you would be willing to be assigned to an individual who:

	YES	NO
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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