

## 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	Pet Visiting
Convalescent Hospital Visiting	Program entertainment
Senior Peer Counseling (age 55 or older)	Special Events (e.g., Concert, Beer & Cider Festival)
Saturday Club (2nd & 4th Saturdays/Davis Sr. Ctr.)	

**Time availability (check all 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
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**Employment:**

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

Name	Address	Phone	How do you know?
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(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 your 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 program applicants and Senior Peer Counseling applications 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
- Senior Peer Counseling (must be age 55 or older)
- 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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