

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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