

Community
Home Health Services
VOLUNTEER APPLICATION

DATE: _____

NAME: _____

ADDRESS: _____
Last First

DATE OF BIRTH: _____ SS#: _____
Street City State Zip

TELEPHONE: Home: _____ Work Phone: _____
Cell: _____ E-Mail: _____
I prefer to be contacted by ___ Home phone ___ Cell Phone ___ Email ___ Work phone

EMERGENCY CONTACT: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

EMPLOYMENT:
Name of Current Employer: _____

VOLUNTEER SERVICE:
Present Volunteer Job(s): _____
Past Volunteer Experience: _____

REASON TO VOLUNTEER:
I want to volunteer for Community Home Health Services because _____

How did you hear about volunteering at Community Home Health Services?
___ Church ___ School ___ Newspaper ___ Other Volunteer/Staff Member ___ Recruitment Event ___ Other

HEALTH: Please describe any limitations. _____

SKILLS & INTERESTS:
Please list any skills, interests or abilities that you would like to share with patients and staff:
(i.e. computer, foreign language, sign language, sewing) _____

Have you ever been discharged from any position? ___ YES ___ NO
If Yes, please explain: _____
Have you ever been convicted of a felony? ___ YES ___ NO
Do you have criminal charges pending? ___ YES ___ NO
If yes, give date and nature of conviction or pending _____

I have lived in Indiana for at least two years ___ YES ___ NO

STUDENT INFORMATION

Education (Circle Last Grade completed)

HIGH SCHOOL : 9 10 11 12

COLLEGE: 1 2 3 4

Name of School: _____ Grade Point Average: _____

Counselor Name: _____ School Phone: _____

Minor (Under 18)

Parental/Guardian Permission: In order for your minor child to volunteer for Community Home Health Services, an up to date immunization record is required. I authorize my child to volunteer for Community Home Health Services and am providing his/her up to date immunization record.

Minor Child's Name: _____

Parent or Guardian's Name:

Printed: _____

Parent or Guardians Signature: _____ Date: _____

Personal References: (Please provide two (2) personal references (not relatives):

1. Reference Name: _____ Phone: _____

Address _____	City _____	State _____	Zip _____
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Email Address: _____

2. Reference Name: _____ Phone: _____

Address _____	City _____	State _____	Zip _____
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Email Address _____

PLEASE READ CAREFULLY:

I certify that statements on this application are true and correct to the best of my knowledge. I understand that Community Home Health Services will make a thorough investigation including a criminal history of my entire personal history and may verify all data given in my application. I authorize such investigation and the giving and receiving of any information required by Community Home Health Services and release from liability any person giving or receiving such information now or in the future. I understand falsification of data given or derogatory information discovered as a result of this investigation may prevent my being accepted as a volunteer, or, if accepted, may subject me to immediate dismissal. I understand that my volunteering depends upon satisfactory references and successful completion of a physical exam, and meeting all other agency requirements. If accepted, I agree to abide by and conform to all rules, policies and procedures of Community Home Health Services.

Signature: _____ **Social Security #:** _____ **Date:** _____

If accepted as a volunteer, I agree that any photograph (still or video recording) in which I appear, taken by any CHNetwork staff or volunteer, may be used, without further authorization, by CHNetwork entities, including CHHS, for any business purpose. Your application/acceptance is not contingent on such agreement, and such agreement is simply sought to avoid further paperwork.

___ Yes ___ No

Volunteer Signature