

**DREAM CENTER VIDALIA
VOLUNTEER PROGRAM APPLICATION**

NAME: _____

DATE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____

PRIMARY PHONE: () _____

CITY/STATE/ZIP: _____

**SECONDARY
PHONE:** () _____

EMERGENCY CONTACT:

NAME: _____

PHONE: _____

RELATIONSHIP: _____

INTERESTS/SKILLS: (please check all useful volunteer skills.)

ANSWERING PHONE: _____

SECRETARIAL/DATA ENTRY, ETC: _____ **DRIVER:** _____

CULINARY/COOKING: _____

TEACHING: _____

EVENT/ACTIVITIES PLANNING: _____

MODERATE EXERCISE: _____

ARTS/CRAFTS: _____

WEB/NEWSLETTER UPDATE: _____

PUBLIC RELATIONS/ADVERTISING: _____

OTHER: (please give brief description)

VOLUNTEER/WORK HISTORY, PLEASE LIST PAST FIVE YEARS:

PLEASE EXPLAIN DESIRE FOR WANTING TO VOLUNTEER AT THE DREAM CENTER:

HOW DID YOU HEAR ABOUT OUR VOLUNTEER OPPORTUNITIES AT THE DREAM CENTER:

PLEASE INDICATE WHAT DAYS AND HOURS YOU ARE AVAILABLE TO VOLUNTEER:

MONDAY: _____ **TUESDAY:** _____ **WEDNESDAY:** _____

THURSDAY: _____ **FRIDAY:** _____ **SATURDAY:** _____ **SUNDAY:** _____

HOW LONG DO YOU PLAN TO VOLUNTEER?

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MEDICAL:

ARE YOU PRESENTLY UNDER MEDICAL CARE? DO YOU HAVE ANY SERIOUS ILLNESS, INJURY, AND/OR RESTRICTIONS THAT WOULD PREVENT YOU FROM PERFORMING ASSIGNED TASKS AND DUTIES AS A VOLUNTEER? _____ IF YES, PLEASE EXPLAIN: _____

MEDICAL SCREENING: DO YOU HAVE A HISTORY OF THE FOLLOWING:

HISTORY:	NEVER	PRESENTLY	IN THE PAST	UNSURE
HEART DISEASE OR HEART ATTACK	_____	_____	_____	_____
RAPID, SLOW OR IRREGULAR HEART BEAT	_____	_____	_____	_____
STROKE	_____	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____	_____
VERICOSE VEINS, BLOOD CLOTS	_____	_____	_____	_____
SHORTNESS OF BREATH	_____	_____	_____	_____
EMPHYSEMA	_____	_____	_____	_____
ASTHMA	_____	_____	_____	_____
TUBERCULOSIS	_____	_____	_____	_____
JAUNDICE/HEPATITIS	_____	_____	_____	_____
EPILEPSY/SEIZURE DISORDER	_____	_____	_____	_____
FAINTING SPELLS/DIZZINESS	_____	_____	_____	_____
PARKINSON'S DISEASE	_____	_____	_____	_____
ARTHRITIS/PAINFUL, SWOLLEN JOINTS	_____	_____	_____	_____
BACK PROBLEMS/BACK SURGERY	_____	_____	_____	_____
HERNIA (RUPTURE)	_____	_____	_____	_____
DIABETES	_____	_____	_____	_____

COMMENTS:

BACKGROUND SCREENING:

PLEASE LIST ANY FELONY OR MISDEMEANOR CONVICTIONS THAT YOU HAVE RECEIVED IN YOUR LIFETIME. SUCH CONVICTIONS MAY/MAY NOT DISQUALIFY YOU FROM VOLUNTEERING BUT MUST BE DISCLOSED TO ASSIST THE DREAM CENTER WITH APPROVING YOU TO VOLUNTEER. FAILURE TO DISCLOSE COMPLETE INFORMATION WILL IMMEDIATELY DISQUALIFY YOU AS A VOLUNTEER.

DO YOU HAVE ANY MISDEMEANORS OR CONVICTIONS? IF SO, PLEASE GIVE A DESCRIPTION OF EACH CHARGE:

YOUR SOCIAL SECURITY NUMBER AND DRIVER'S LICENSE INFORMATION WILL BE COLLECTED TO CONDUCT A BACKGROUND CHECK AND WILL BE MAINTAINED IN STRICT CONFIDENCE IN YOUR VOLUNTEER FILE.

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I THE UNDERSIGNED CERTIFY THE PREVIOUS BACKGROUND INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I HEREBY AUTHORIZE, WITHOUT RESERVATION, ANY LAW ENFORCEMENT AGENCY, ADMINISTRATOR, STATE OR FEDERAL AGENCY INSTITUTION AND EMPLOYER TO FURNISH ANY AND ALL BACKGROUND INFORMATION REQUESTED BY THE DREAM CENTER AND/OR OUTSIDE ORGANIZATION ACTING ON BEHALF OF THE COMPANY, AND/OR COMPANY ITSELF.

APPLICANT SIGNATURE: _____

DRIVER LICENSE#: _____

STATE: _____