Aging & Disability Resource Center – Grant County  
Volunteer Application

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| Name: Click here to enter text. | | Date: Click here to enter text. |
| Address: Click here to enter text. | | |
| Telephone: Click here to enter text. | Birthdate: Click here to enter text. | |

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| Check the type of volunteer service you are interested in: | |
|  | Assist at Meal Site |
|  | Meal Delivery |
|  | Drive Clients to Medical Appointments |
|  | Other (please describe) Click here to enter text. |

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| --- | --- | --- | --- | --- |
| Present/Past Work Experience: | | Please describe your present or past work experience | | |
| Skills/Knowledge: | | Please list your skills or knowledge pertaining to application | | |
| Do you have physical limitations that would affect your volunteer service? | | | Yes | No |
| If yes, explain | Please explain physical limitations | | | |
| Do you have time limitations that would affect your volunteer service? | | | Yes | No |
| If yes, explain | Please explain time limitations | | | |

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| Emergency Contact Person: | | Click here to enter text. | | |
| Day Phone Number: | Click here to enter text. | | Night Phone Number: | Click here to enter text. |

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| Please provide us with the name & phone number of three references who are not related to you. | | | |
| Name: | Click here to enter text. | Phone: | Click here to enter text. |
| Name: | Click here to enter text. | Phone: | Click here to enter text. |
| Name: | Click here to enter text. | Phone: | Click here to enter text. |

# PLEASE COMPLETE ALL SHEETS

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| The following information is needed if you are applying for a driving position. | | | | |
| Social Security Number: | Click here to enter text. | | | |
| Driver’s License Number: | Click here to enter text. | Expiration Date: | Click here. | |
| Vehicle Information: | Make, Model, Year: | Click here to enter text. | | |
|  | Insurance Company: | Click here to enter text. | | |
|  | Insurance Agent: | Click here to enter text. | | |
| Insurance Coverage: | $ Click here to enter text. | Bodily Injury Liability per Person | | |
|  | $ Click here to enter text. | Bodily Injury Liability per Accident | | |
|  | $ Click here to enter text. | Property Damage Liability per Accident | | |
| Are you willing to take clients that smoke: | | Yes | | No |
| AUTO POLICY – I understand that if I use my personal vehicle during volunteer service: I will maintain auto insurance as required by low. It is my responsibility to contact my insurance company and inform them that I am volunteering for the ADRC. | | | | |

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| CONFIDENTIALITY - Clients have a right to confidential arrangements, conversations and procedures. I fully understand that as a condition of my volunteer service, I will not disclose or discuss personal information of clients except as my volunteer service requires it within the context of the professional agency requirements. And, I will endeavor to protect the confidentiality of clients at all times. | |
| *I hereby certify that all statements made on or in connection with this application are true, complete and correct to the best of my knowledge and belief, and I understand and agree that any misstatements or omissions of material fact herein subjects me to disqualification or dismissal. I authorize a release of any records pertaining to my education, employment, and/or personal references to Grant County. I voluntarily agree to cooperate in such investigation and release from all liability of responsibility all persons, companies or corporation supplying or acting upon such information. I also give the Aging & Disability Resource Center permission to check my driving record (if applicable), contact the references I have given and to do criminal background check.* | |
| Print Name: | Click here to enter text. |
| Signature: | Click here to enter text. |
| Date: | Click here to enter text. |
| Please return completed application & waiver via email or mail: [adrc@co.grant.wi.gov](mailto:adrc@co.grant.wi.gov) or  ADRC, PO Box 383, Lancaster, WI 53813 | |

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| **Aging & Disability Resource Center**  **P.O. Box 383 8820 Hwy. 35/61/81 Lancaster, WI 53813**  **(608) 723-6113 or 1-800-514-0066 Fax (608)-723-6122** | |
| VOLUNTEER APPLICANT WAIVER  AND  AUTHORIZATION FOR RELEASE OF INFORMATION | |
| TO WHOM IT MAY CONCERN:  I authorize all Persons, Schools, Companies, Corporations, Agencies, Credit Bureaus, Municipalities, Agencies, or other Organizations to give to Aging & Disability Resource Center, Grant County any information requested concerning my employment, character, experience, and qualifications and/or suitability for employment with Grant County, including a check of my fingerprints, motor vehicle record and criminal record for the purpose of considering my suitability for hire. I hereby forever release, discharge, and covenant not to sue any person or organization for any result of providing, obtaining, or acting upon such information. I agree to release all parties from all claims under any laws, including civil rights laws, arising from providing and receiving such information. I understand that such information is sought with confidentiality and will not be released to me in any form whatsoever.  In addition, a copy of this authorization is as valid as the original and should be recognized as such.  I further understand that I may be asked to undergo a physical examination, including substance abuse screening, prior to an appointment to a position with Grant County. Refusal to participate will result in the rejection of my application: | |
| Signature of Applicant: | Click here to enter text. |
| Print Full Name (First, Middle, Last): | Click here to enter text. |
| Date: | Click here to enter text. |
| Social Security Number: | Click here to enter text. |
| Date of Birth: | Click here to enter text. |
| Driver’s License Number: | Click here to enter text. |
| State of Issue: | Click here to enter text. |