Aging & Disability Resource Center – Grant County
Volunteer Application

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| Name:  | Date:  |
| Address:  |
| Telephone:  | Birthdate:  |

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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)  |

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| --- | --- |
| Present/Past Work Experience: |  |
| Skills/Knowledge: |  |
| Do you have physical limitations that would affect your volunteer service? | Yes [ ]  | No [ ]  |
| If yes, explain |  |
| Do you have time limitations that would affect your volunteer service? | Yes [ ]  | No [ ]  |
| If yes, explain |  |

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| --- | --- |
| Emergency Contact Person: |  |
| Day Phone Number: |  | Night Phone Number: |  |

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

# PLEASE COMPLETE ALL SHEETS

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| The following information is needed if you are applying for a driving position. |
| Social Security Number: |  |
| Driver’s License Number: |  | Expiration Date: | Click here. |
| Vehicle Information: | Make, Model, Year: |  |
|  | Insurance Company: |  |
|  | Insurance Agent: |  |
| Insurance Coverage: | $  | Bodily Injury Liability per Person |
|  | $  | Bodily Injury Liability per Accident |
|  | $  | 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: |  |
| Signature: |  |
| Date: |  |
| Please return completed application & waiver via email or mail: 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 WAIVERANDAUTHORIZATION 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: |  |
| Print Full Name (First, Middle, Last): |  |
| Date:  |  |
| Social Security Number: |  |
| Date of Birth: |  |
| Driver’s License Number: |  |
| State of Issue: |  |