

Aging & Disability Resource Center – Grant County Volunteer Application

Name: _____ Date: _____

Address: _____

Telephone: _____ Birthdate: _____

Check the type of volunteer service you are interested in:	
<input type="checkbox"/>	Assist at Meal Site
<input type="checkbox"/>	Meal Delivery
<input type="checkbox"/>	Drive Clients to Medical Appointments
<input type="checkbox"/>	Other (please describe)

Present/Past Work Experience:			
Skills/Knowledge:			
Do you have physical limitations that would affect your volunteer service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, explain			
Do you have time limitations that would affect your volunteer service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, explain			

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

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

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 <input type="checkbox"/>	No <input type="checkbox"/>	
<p>AUTO POLICY – I understand that if I use my personal vehicle during volunteer service: I will maintain auto insurance as required by law. It is my responsibility to contact my insurance company and inform them that I am volunteering for the ADRC.</p>			

<p>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.</p> <p><i>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.</i></p>	
Print Name:	
Signature:	
Date:	
<p>Please return completed application & waiver via email or mail: adrc@co.grant.wi.gov or ADRC, PO Box 383, Lancaster, WI 53813</p>	

**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:	
Print Full Name (First, Middle, Last):	
Date:	
Social Security Number:	
Date of Birth:	
Driver's License Number:	
State of Issue:	