

West Central District Health Department

ADULT VOLUNTEER APPLICATION

NAME _____ BIRTHDATE _____
LAST FIRST

HOME ADDRESS _____
STREET CITY ZIP

HOME PHONE _____ WORK PHONE _____

DOCTOR _____ PHONE _____

EMERGENCY CONTACT _____

PREVIOUS WORK EXPERIENCE _____

PREVIOUS VOLUNTEER EXPERIENCE _____

PHYSICAL DISABILITIES WHICH MAY RESTRICT VOLUNTEER WORK ASSIGNMENTS

EDUCATION / SPECIAL TRAINING _____

HOBBIES / SKILLS / SPECIAL INTERESTS _____

REFERENCE _____ PHONE _____
(NOT A FAMILY MEMBER)

TIME YOU WOULD NOT BE AVAILABLE TO VOLUNTEER _____

I WISH TO DONATE MY SERVICES TO WEST CENTRAL DISTRICT HEALTH DEPARTMENT AND UNDERSTAND THERE IS NO PAYMENT FOR SERVICES RENDERED UNDER THE VOLUNTEER PROGRAM. I AGREE TO ABIDE BY THE RULES, REGULATIONS, AND POLICIES OF THE PUBLIC HEALTH DEPT. I FURTHER UNDERSTAND CONFIDENTIALITY MUST BE MAINTAINED AT ALL TIMES CONCERNING CLIENT AND FAMILY INFORMATION. I UNDERSTAND THAT FROM TIME TO TIME THE PUBLIC HEALTH DEPARTMENT MAY TAKE PHOTOGRAPHS TO BE USED IN MEDIA PUBLICATIONS.

SIGNATURE _____ DATE _____