



Services that heal, strengthen, and provide hope

Volunteer Application

CMS Care Team Program

Contact Information

Today's Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Cell: _____ Work: _____

Fax: _____ E-mail: _____

Emergency contact name: _____ Phone: _____

Name of church you attend: _____

Skills and Interests

Educational background: _____

Current employer/Former employer (if retired): _____

Position/Title: _____

Previous volunteer experience: _____

What experiences or training do you have that prepares you to work with older adults?

What do you hope to gain from this volunteer experience? _____

Do you have any other special training, skills, and hobbies? _____

Desired Volunteer Role(s) and Availability

Care Team Member _____ Team Leader _____ Church Liaison _____

Other (Please explain): _____

How many hours a month can you volunteer? _____

What days and times work best for you? _____

References

Please list three people who know you well and are not related to you.

Name & number of personal reference: _____

Name & number of personal reference: _____

Name & number of personal reference: _____

Legal Information

Do you have a driver's license? Yes No Car Insurance? Yes No

Have you ever been convicted of a crime? (If yes, please explain)

Please read the following carefully before signing this application:

I understand that this is an application for and not a commitment to or promise of participation in this volunteer opportunity. I certify that the information on this application is true and complete to the best of my knowledge. I hereby consent for Care Management Solutions to investigate or verify this information as it relates to my suitability as a volunteer. I understand any misrepresentation of the facts on the application or in interviews with Care Management Solutions staff may be cause for immediate termination of my application for the volunteer support team ministry program.

Signature: _____ Date: _____