





Administrative Office: 300 South Adams Street.  
 Green Bay, WI 54301  
 (920) 448-4300, Fax: 448-4302, TTY: 448-4335

# Volunteer Registration

How did you learn of the vol. opportunity? \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Male  Female   
 (First, Last, M.I.)

Address: \_\_\_\_\_ No. of yrs at address \_\_\_\_\_  
 (Street, City, State and Zip Code)

Previous address if less than 5 years at above address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

May we contact you at work: No  Yes  Work Phone: \_\_\_\_\_

Do you have any conditions, which may limit your ability to serve in any volunteer capacities, i.e.: lifting, time of day, etc.? No  Yes . If yes please explain \_\_\_\_\_

<b>Emergency Contact:</b>	Name: _____	
	Relationship: _____	
	Address: _____	
	Home Phone: _____	Work Phone: _____

**Check off the types of volunteer work you would be interested in:**

- Exercise Room
- Collating, Copying, Filing
- Computer Data Input
- Group Leader i.e.: woodworking, arts/crafts, exercise, foreign language for \_\_\_\_\_ Language.
- Visiting homebound
- Phoning homebound
- Shopping/errands escort
- Delivering meals
- Helping at meal sites
- Appointment escort

List other interests or skills you want to share: \_\_\_\_\_

**References:** (List three complete references, including volunteer and work experience if any.)

Name	Street	City, State, Zip Code	Relationship	Years Known

**Background Check:** The Aging & Disability Resource Center assures clients and their families that all volunteers have been screened so that they can feel secure about who is serving them or their loved one.

- Have you ever been legally known by any other name? If yes, please list: \_\_\_\_\_
- Have you ever been convicted of anything other than a minor traffic violation? If yes, please explain: \_\_\_\_\_

**Vehicle Insurance Information:**

I understand that if I use my personal automobile in my Volunteer Service, I will arrange to keep in effect automobile liability insurance equal to the minimum limits required by our state. (Please attach a copy of your insurance card or “declarations page” or have your insurance agent send us a “Certificate of Insurance” on your policy.)

Driver’s License No.: \_\_\_\_\_ Car License No.: \_\_\_\_\_

**Accidental Death and Dismemberment Insurance Information:**

This insurance is part of the umbrella liability coverage. Please designate a beneficiary here:

Name	Relationship	Address, City, State, Zip
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**Please read all of the following statements before signing**

**Confidentiality Agreement:**

I agree to abide by State of Wisconsin law by keeping all information concerning persons served strictly confidential. I will not use or give the name(s) or any other information regarding the person(s) whom I serve to anyone other than authorized personnel at the Aging & Disability Resource Center or to the 911 Operator or other emergency personnel in the case of an emergency.

**Authorization:**

- I hereby authorize the Aging & Disability Resource Center to contact the references listed on this form. I hereby authorize said agency to investigate my background and character, whether this information is of public record or not.
- I certify that my statements in this application are true, complete and correct to the best of my knowledge and belief and understand and agree that any misstatements or omissions of fact on this application constitutes grounds for rejection or termination from this volunteer program.
- I hereby irrevocably consent to and authorize the use and reproduction by the Aging & Disability Resource Center of Brown County, or anyone authorized by them, of any and all photographs which they have taken of me, for display, publication, publicity or any other purpose whatsoever without my name, without compensation to me, and without further inspection by me.

**For Statistical Purposes only:**

- |   |  |                                      |   |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> NON-MINORITY     | <input type="checkbox"/> AMERICAN INDIAN | <input type="checkbox"/> HISPANIC    | <input type="checkbox"/> ASIAN AMERICAN |
| <input type="checkbox"/> AFRICAN AMERICAN | <input type="checkbox"/> NATIVE HAWAIIAN | <input type="checkbox"/> MULTIETHNIC | <input type="checkbox"/> OTHER          |

Signature of Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_

**COMMITMENT TO NON-DISCRIMINATION**

In accordance with Civil Rights Compliance Standards, you will not be denied services or discriminated against because of religion, age, race, sex, disability, physical condition, sexual orientation or developmental disability. Reasonable accommodations will be made for disabilities in accordance with the Americans with Disabilities Act. If you require such an accommodation, please contact the Aging & Disability Resource Center 72 hours prior to the need for the accommodation. If you are denied services for any reason and would like to file a grievance form, you may receive a copy of this form by calling (920) 448-4300. The TTY telephone number for the hearing impaired is (920) 448-4335.

For Office	<input type="checkbox"/> DN	<input type="checkbox"/> PUL	<input type="checkbox"/> DP	<input type="checkbox"/> SC	<input type="checkbox"/> MP	<input type="checkbox"/> PP
Use Only	<input type="checkbox"/> MM	<input type="checkbox"/> CUR	<input type="checkbox"/> Cloud Dist.	<input type="checkbox"/> LTC	<input type="checkbox"/> FH	<input type="checkbox"/> BT