Family Health West
PO Box 130 Fruita CO 81521

Adult Volunteer Application

LAST NAME	FIRST NAME	DATE OF BIRTH
ADDRESS	MAILING ADDRESS	EMERGENCY CONTACT
EMAIL ADDRESS		EMERGENCY CONTACT #

CITY	STATE	ZIP CODE	HOME PHONE #	CELL PHONE #

Do you have any physical or medical limitations?____

Have you ever been employed by Family Health West? ❑ yes ❑ no Area: ________________________

Please select area(s) of interest

Frequency: ❑ weekly ❑ bi-weekly ❑ every other week ❑ monthly

Time per Frequency: ❑ 1 hr ❑ 2 hrs ❑ 3 hrs

Day of Week: ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday ❑ Sunday

Time of Day: ❑ morning ❑ afternoon ❑ evening

Prefer Working: ❑ individually ❑ in a group ❑ as a group - Name of Group: ____________________

Area Preferred: ❑ Hospital ❑ Nursing Home ❑ Assisted Living ❑ Office

Other Considerations: ____

Please list your special skills, talents, and interests: ____
____

Please list three character references (please do not use relatives):

Name ______________________	Name ______________________	Name ______________________
Address ____________________	Address ____________________	Address ____________________
___________________________	___________________________	___________________________
Phone # ____________________	Phone # ____________________	Phone # ____________________

______________________________________ ____________________
SIGNATURE DATE

Thank you for your interest. Applicant will be called by Volunteer Coordinator.

For Office Use Only:

C-203 1110 0714

CONSENT FORM
FOR BACKGROUND CHECK

Applicant, please complete the following:

The following information is required by law enforcement agencies and other entities for positive identification when checking records. It is confidential and will not be used for other purposes.

Print Full Name (last, first, middle): ______________________________

Print other names used: ______________________________

Date of Birth: ______________ Social Security #: ______________

Driver's License #: ______________ State of Issue: ______________

Race: Asian ρ❑ Black ρ❑ Hispanic ❑ White ❑ Other ❑ρ Sex: Male ❑ Female ❑ ρ

List address(es) for the past five years
Include city, state, zip code, and how long you lived there. List current address first.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

By signing the below, I hereby authorize Family Health West to contact me and my listed references and use the information entered on this form for the Volunteer Application process and file/information storing.

I understand that a condition of volunteering at Family Health West is a screening test for tuberculosis. Upon completion of the volunteer interview and initial volunteer on boarding process, it is the responsibility of the volunteer or the parent of the volunteen to contact the Access Clinic at 970-858-2190 to schedule their TB test, the follow up visit, the second TB test and the second follow up visit. If the results of this test are positive, I understand that a chest x-ray will be done. Family Health West agrees to do the screen and/or x-ray free of charge.

I acknowledge that I will also be required to complete a drug screening prior to volunteer service. Family Health West is determined to eliminate the use of illegal drugs, alcohol and controlled substances. This program is designed solely for the benefit of volunteers and employees, to provide reasonable safety while on duty, and to protect them and patients / residents from offending individuals. Additionally, this program meets Family Health West's commitment to the community it serves.

I also authorize Family Health West to perform a Criminal Background Check. In connection with this request, I authorize all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, county, state, and federal courts, military services and persons, CBI, and FBI, to release information they may have about me to the person or their agent or company with which this form has been filed. This releases the aforesaid parties from any liability and responsibility for collecting the above information. This authorization, in original form or copy form, shall be valid for this and any future reports or updates that may be requested.

I authorize the procurement of my Colorado Worker's Compensation files or any other states' Worker's Compensation files. I also authorize a consumer credit report to be run. I understand these files may contain negative information about my background, mode of living, character and personal reputation. This authorization, in original form or copy form, shall be valid for this and any future reports or updates that may be requested.

______________________________ ______________________________
Volunteer Applicant's Signature Date

Volunteer Coordinator Requesting: ______________________ Ext.________