APPLICATION FOR VOLUNTEER POSITION
COUNCIL ON AGING, INC., serving St. Clair County
600 Grand River, Port Huron, MI  48060, (810) 987-8811

INSTRUCTIONS: Answer all questions. Questions may be position related or required by state or federal law.
It depends upon the type of position for which you are applying. Your answers will not be considered unless the information is related to the position for which you are applying.

Today’s Date:

Volunteer Position(s) Applying For:

Last  First  Middle
Name:_______________________________Name:_________________Name:______________________

Street Address with Apt. Number:

City/State/Zip Code:

Phone  Social  Date
Number:_______________________Security Number:______________________of Birth:_____/_____/_____

Driver’s License Number:  State Issued In:

Do you have a Commercial Driver’s License?  Do you have a Chauffeur’s License?
Yes  No  Yes  No
Do you have transportation?  My own car  Someone will transport me  No  I need a ride
I am applying to do volunteer work from my home:  Yes  No

(A yes answer to either of the two following questions does not automatically disqualify you.)

Have you ever been convicted of a crime other than a minor traffic violation?  Yes  No
If yes, please explain: ______________________________________________________________________

Have there felony charges pending against you?  Yes  No
If yes, please explain:

If yes, please explain:

Have you ever been employed by the Council on Aging?  Yes  No
If yes:  Dates worked: ___________________________ Department/Position:

Interests/Hobbies/Special Skills:

Organizations Affiliated With:

Please list any other training, apprenticeships, military or work experiences that relate to your volunteering: ___

EMPLOYMENT HISTORY:

Previous Volunteer Experience: (Attach additional sheets if needed.)

Organization:  Position:  Person with whom you worked:  Duties:  
Organization:  Position:  Person with whom you worked:  Duties:  

Most Recent Employer:

Company Name:  Position Held:  Address:  City:  State:  Zip Code:  Phone Number: (  )

Supervisor & Department:

Briefly Describe Your Duties:

CoA-7 4/96; 2/07; 5/08, 6/08, 6/09; 12/15
List other employment positions you have held:___________________________________________________
____________________________________________________________________________________________
________________________________________________________________________________________

MEDICAL HISTORY:
Do you have any physical, mental or medical impairments which may interfere with your ability to do the work for which you have volunteered?  □ Yes  □ No
If yes, please explain: _______________________________________________________________________

Your Physician’s Name: _______________________________ Phone Number: _________________________

May we contact them, if necessary, relative to your physical condition?  □ Yes  □ No

Are you currently taking any drugs or medication?  □ Yes  □ No
If yes, please explain: _______________________________________________________________________

In Case of an Emergency CoA Should Contact:
Name: ______________________________________  Address: _____________________________________
Home Phone Number: ____________________________________ Relationship: _______________________
Work Phone Number: _______________________________ Cell Phone Number: _______________________

If your personal doctor is not available, can another trained medical attendant administer treatment?  □ Yes  □ No
Hospiat Preference: ________________________________________________________________________

I certify that all the statements made in this application for volunteering are true, complete and correct to the best of my knowledge and belief. I also understand that any false information or omissions may result in my being asked to leave the Council on Aging volunteer program(s).

Signature of Applicant ________________________________ Date Signed _____________________________

Applicants for positions with fiscal responsibilities, working with confidential records, or driving must complete the following:
As a prospective volunteer of the Council on Aging, Inc., I understand that it is this agency’s policy to secure conviction criminal history information and/or driving record reports as part of its screening process using information provided on this application as well as the following information: Maiden Name and/or previous names used: ____________ Race: _______________________

I understand the Central Records Division of the Michigan State Police, Lansing, Michigan, requires the aforementioned information. I hereby authorize the Council on Aging, Inc. to utilize the above information for the sole purpose of obtaining a conviction only criminal history file search and/or driving record check.

Signature of Applicant ________________________________ Date Signed _____________________________

Application received: ____________________________ by: ________________________________
Reviewed by: ________________________________ on ________________________________
Referred to: ________________________________ on ________________________________
Applicant called regarding status/start date: ________________________________ by: ________________________________
Criminal (Date: _______________) Driving (Date: _______________)