

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Aging and Adult Administration

VOLUNTEER'S REGISTRATION

VOLUNTEER'S NAME *(Last, First, M.I.)* HOME PHONE NO.

()

ADDRESS *(No., Street, City, State, ZIP)* WORK PHONE NO.

()

MAILING ADDRESS *(If different)*

CURRENT/PREVIOUS EMPLOYMENT

CURRENTLY EMPLOYED CURRENT/PREVIOUS OCCUPATION TITLE

Yes No

CURRENT OR LAST EMPLOYER'S NAME

EMPLOYER'S ADDRESS *(No., Street, City, State, ZIP)*

SUPERVISOR'S NAME PHONE NO.

()

LENGTH OF EMPLOYMENT DESCRIPTION OF DUTIES

SUMMARY OF EMPLOYMENT HISTORY

PRIOR VOLUNTEER EXPERIENCE

EDUCATION

| High School, College, University, Trade/Business School | City & State | Dates Attended Mo./Yr. to Mo./Yr. | Diploma/Degree and Date Received | Sem. Hours | Major Area of Study |
|--|--------------|--------------------------------------|-------------------------------------|---------------|------------------------|
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| | | | | | |

SPECIAL SKILLS/TRAINING/CERTIFICATION/LICENSES

INTERESTS/HOBBIES

LANGUAGES SPOKEN LANGUAGES READ

TRANSPORTATION

| | | | | |
|-------------------------------|-----------------|---|--|---|
| DRIVER'S LICENSE NO. | EXPIRATION DATE | CAR AVAILABLE <input type="checkbox"/> Yes <input type="checkbox"/> No | WILLING TO TRANSPORT <input type="checkbox"/> Yes <input type="checkbox"/> No | DO YOU HAVE LIABILITY INSURANCE <input type="checkbox"/> Yes <input type="checkbox"/> No |
| AUTO INSURANCE COMPANY'S NAME | | | POLICY NO. | EXPIRATION DATE |

AVAILABILITY

DO YOU HAVE HEALTH PROBLEMS WHICH MIGHT AFFECT YOUR ABILITY TO WORK

Yes No If Yes, Explain:

| | | |
|---|--|-------------------------------------|
| ARE THE DAYS/HOURS YOU ARE AVAILABLE FLEXIBLE <input type="checkbox"/> Yes <input type="checkbox"/> No | IF NO, INDICATE THE DAYS AND HOURS PER DAY YOU ARE WILLING TO WORK | NO. OF HOURS AVAILABLE PER MONTH |
|---|--|-------------------------------------|

PREFERENCES

INDICATE YOUR PREFERENCE TO WORK WITH:

Children Adults Transportation No Preference Other:

REFERENCES (Person(s) not related to you)

| | |
|------|------------------|
| NAME | PHONE NO. () |
|------|------------------|

ADDRESS (No., Street, City, State, Zip)

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|------|------------------|
| NAME | PHONE NO. () |
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ADDRESS (No., Street, City, State, Zip)

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| NAME | PHONE NO. () |
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ADDRESS (No., Street, City, State, Zip)

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|------|------------------|
| NAME | PHONE NO. () |
|------|------------------|

ADDRESS (No., Street, City, State, Zip)

REASON FOR VOLUNTEERING

REASON

HOW DID YOU LEARN ABOUT THE DES VOLUNTEER PROGRAM

STATEMENT OF CERTIFICATION

Have you ever been convicted of or found by a court to have committed a sex offense, drug- related offense, a violence- related offense, child abuse, child neglect or contributing to the delinquency of a minor? Yes No

ARE YOU WILLING TO BE FINGERPRINTED IF REQUIRED

Yes No

I verify that the above responses are true to the best of my knowledge. I agree to have DES check the references which I have listed above.

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| VOLUNTEER'S SIGNATURE | DATE |
|-----------------------|------|