



Calhoun County Medical Care Facility

Marian E. Burch Adult Day Care

Sharing and caring through the years

VOLUNTEER APPLICATION

Application must be signed and dated. Please mail or drop off at the receptionist desk.

PLEASE PRINT LEGIBLY USING BLACK OR BLUE INK ONLY

APPLICANT INFORMATION			
NAME:		DATE OF BIRTH:	
ADDRESS:			
CITY:		STATE:	ZIP CODE:
DAYTIME PHONE: ()	EVENING PHONE: ()		ALTERNATE PHONE: ()
E-MAIL ADDRESS:			
EMERGENCY CONTACT INFORMATION			
NAME:		RELATIONSHIP:	
DAYTIME PHONE: ()	EVENING PHONE: ()		ALTERNATE PHONE: ()
SCHOOL/EMPLOYMENT/VOLUNTEER HISTORY			
SCHOOL/EMPLOYER:		OCCUPATION:	
RETIRED FROM:			
PLEASE LIST WORK OR VOLUNTEER EXPERIENCES, INCLUDING INTERNSHIPS:			
VOLUNTEER INTERESTS			
LIFE ENRICHMENT			
<input type="checkbox"/>	READING (WITH INDIVIDUAL RESIDENT OR GROUP)	<input type="checkbox"/>	ART & CRAFTS/GAMES (ASSIST STAFF AND RESIDENTS)
<input type="checkbox"/>	GARDENING (INDOOR, OUTDOOR, WEEDING, PLANTING, WATERING, ETC.)	<input type="checkbox"/>	BINGO (CALLING, ASSISTING RESIDENTS, PRIZE CART, ETC.)
<input type="checkbox"/>	CARD GAMES (RUMMY, BLACK JACK, EUCHRE, PINOCHLE, ETC.)	<input type="checkbox"/>	KNITTING, CROCHETING, QUILTING, ETC.
<input type="checkbox"/>	FRIENDLY VISITOR (PROVIDE 15-30 MIN. OF INTERACTION)	<input type="checkbox"/>	OUTINGS (ACCOMPANY AND ASSIST A RESIDENT)
OTHER AREAS			
<input type="checkbox"/>	APPOINTMENT COMPANION (RIDE ALONG TO OUTSIDE APPOINTMENT AND PROVIDE COMPANIONSHIP TO RESIDENT—DIRECT CARE IS NOT REQUIRED)		
<input type="checkbox"/>	CLERICAL (ASSIST WITH INFORMATION GATHERING, FILING, PREPARING PAPERWORK FOR DISTRIBUTION, ETC.)		
<input type="checkbox"/>	FUNDRAISING (ASSIST WITH PLANNING AND/OR RUNNING FUNDRAISING EVENTS)		
<input type="checkbox"/>	CAPTURE LIFE STORIES (RECORD RESIDENTS' LIFE STORIES USING WRITTEN FORMAT, TYPED VIA INTERNET OR VIDEO VIA IPAD)		
<input type="checkbox"/>	COMPUTER ASSISTANCE (ASSIST RESIDENTS WITH NAVIGATION OF INTERNET, E-MAIL AND LETTER-WRITING, ETC.)		
ADDITIONAL SKILLS AND INTERESTS			
PLEASE LIST OTHER INFORMATION THAT MAY HELP US PLACE YOU AS A VOLUNTEER (HOBBIES, INTERESTS, EDUCATION, ETC.)			

(OVER)

REASONS FOR VOLUNTEERING												
PERSONAL FULFILLMENT				FAMILY/FRIENDS INVOLVED IN SERVICE								
EXTRA TIME				PROFESSIONAL DEVELOPMENT								
SERVICE LEARNING PROJECT*				COMMUNITY SERVICE PROGRAM**								
*NAME OF SCHOOL:						**NAME OF PROGRAM:						
# OF HOURS NEEDED:						# OF HOURS NEEDED:						
AVAILABILITY (PLEASE SELECT APPROPRIATE DAYS AND TIMES THAT BEST FIT YOUR SCHEDULE)												
MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		WEEKENDS (AS NEEDED)		
DAILY		WEEKLY		BI-WEEKLY		MONTHLY		CALL ME WHEN OPPORTUNITIES ARISE				
QUESTIONS												
PLEASE EXPLAIN ANY CONDITIONS WHICH MAY AFFECT YOUR ABILITY TO VOLUNTEER WITHIN OUR FACILITY:												
I AM INTERESTED IN VOLUNTEERING AT: <input type="checkbox"/> CCMCF-Nursing Home <input type="checkbox"/> MBADCC-Adult Day Care <input type="checkbox"/> Wherever the need is most												
THIS POSITION MAY REQUIRE YOU TO PUSH WHEELCHAIRS. ARE YOU ABLE TO DO THIS WITH OR WITHOUT REASONABLE ACCOMMODATION?									YES	NO		
HAVE YOU EVER RECEIVED A TB SKIN TEST?			YES	NO	IF YES, DID YOU HAVE A POSITIVE RESULT?				YES	NO		
VOLUNTEER SIGNATURE									DATE			



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CRIMINAL BACKGROUND CHECK CONSENT FORM

PLEASE COMPLETE, SIGN AND DATE FORM BELOW AND SUBMIT WITH YOUR VOLUNTEER APPLICATION

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FIRST NAME	MIDDLE NAME	LAST NAME	
MAIDEN NAME/OTHER NAME(S) PREVIOUSLY USED			
BIRTH DATE	AGE	RACE	GENDER (CIRCLE ONE) M F
<p>AS A PROSPECTIVE VOLUNTEER OF CALHOUN COUNTY MEDICAL CARE FACILITY, I UNDERSTAND THAT THE ABOVE INFORMATION IS REQUIRED BY THE CENTRAL RECORDS DIVISION OF THE MICHIGAN STATE POLICE, LANSING, MICHIGAN.</p> <p>I AUTHORIZE CALHOUN COUNTY MEDICAL CARE FACILITY TO UTILIZE THE ABOVE INFORMATION FOR THE SOLE PURPOSE OF OBTAINING AN ANNUAL CRIMINAL BACKGROUND FILE SEARCH.</p>			
SIGNATURE OF VOLUNTEER APPLICANT			DATE

FOR OFFICE USE ONLY:

PLEASE INITIAL AND DATE ONCE COMPLETED