



**VOLUNTEER CHORE SERVICES
VOLUNTEER REGISTRATION FORM**

Name: _____ Phone: _____ (Home) _____ (Work)

Address: _____ City: _____ Zip Code: _____

Date of Birth: _____ Optional, Gender: _____ Ethnicity: _____

Occupation: _____ E-Mail: _____

If you will be using your car at any time as a volunteer, it is necessary for our office to record the following information:

- a. Valid driver's license? Yes No
If yes, please list driver's license number: _____ State: _____
- b. I have at least the minimum auto insurance required by the State of Washington (\$25,000 liability per person, \$50,000 liability and \$10,000 property damage per occurrence.)
 Yes No If yes, please list insurance company name: _____

Have you ever been convicted of a felony? Yes* No

*An affirmative answer does not necessarily bar you from volunteer work.

Because our clients are designated by the State as a vulnerable population, all volunteers are required to authorize a records check by the Washington State Patrol. **Please complete Section C and the Applicant Information portion of Section D (Signature required) on the attached form and return it with your registration.** You will be notified of the results of the State Patrol Check.

I would like to help with the following tasks:

- | | | |
|--|--|---|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Laundry | <input type="checkbox"/> *Cooking |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Housework | <input type="checkbox"/> Wood Provision |
| <input type="checkbox"/> *Personal Care | <input type="checkbox"/> *Protective Supervision | <input type="checkbox"/> Communications |
| <input type="checkbox"/> Household Repairs | <input type="checkbox"/> Yard Care | <input type="checkbox"/> Monitoring |
| <input type="checkbox"/> Moving Assistance | | |

*Tasks which require special training or licensing.

I have special training I would be willing to use:

- | | | |
|--|--|---|
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Mental Health Training |
| <input type="checkbox"/> Nursing Assistant | <input type="checkbox"/> HIV/AIDS Training | <input type="checkbox"/> Cosmetology (Manicure, Pedicure, etc.) |
| <input type="checkbox"/> Food Handler's Permit | <input type="checkbox"/> Personal Care Training in _____ | |

If you have any special training, please attach a copy of certification of special training or license.

OVER

I am available to volunteer:

How Often?	Times of Day?	Preferred Assignment?
<input type="checkbox"/> Weekly	<input type="checkbox"/> Mornings	<input type="checkbox"/> Ongoing Client
<input type="checkbox"/> Twice a Month	<input type="checkbox"/> Afternoons	<input type="checkbox"/> Short-Term Client
<input type="checkbox"/> Monthly	<input type="checkbox"/> Evenings	<input type="checkbox"/> No Preference
	<input type="checkbox"/> Days/Times Available	

I am willing to volunteer in the following geographical area(s)

Are you willing to travel outside of the county? Yes No

If yes, please specify county(s): _____

Are you fluent in another language? Yes No

If yes, please specify: _____

Do you have any physical limitations? Yes No

If yes, please specify: _____

Do you have any allergies? Yes No

If yes, please specify: _____

Emergency Contact _____ Relationship: _____ Phone: _____

It is necessary for our office to have three references on file (please do not list relatives). Please fill out completely:

Name: _____ Phone: _____ (Home) _____ (Work)

Address: _____ City: _____ Zip Code: _____

Name: _____ Phone: _____ (Home) _____ (Work)

Address: _____ City: _____ Zip Code: _____

Name: _____ Phone: _____ (Home) _____ (Work)

Address: _____ City: _____ Zip Code: _____

Additional Comments: _____

How did you hear about Volunteer Chore Services? _____

Signed: _____ Date: _____

Please return completed form to your Volunteer Chore Office at: