STRATFORD SENIOR SERVICES
VOLUNTEER APPLICATION

First Name ____________________ Last Name ________________________

Address ____

City, State, Zip Code ____

Telephone(s) ____

Date of Birth _________________________________

Gender: Male Female

Education (highest level completed) ____________________________________

Physical Limitations: No Yes (please explain)

Transportation: (how will you get to your assignment)?

Public Trans. Walk Car Other

List Previous Volunteer Experience:

____

____

____

____

What special skills or talents do you have?

____

____

____

____

What special interests do you have?

____

____

Days and Times Available for Volunteering:

Mondays Tuesdays Wednesdays Thursdays Fridays

Mornings Afternoons

Emergency Contact Information:

First Name ____________________ Last Name ______________________

Relationship to Self _________________________________

Address ____

Telephone(s) ____

Please read and sign:

I understand that this is an application for but not a commitment or promise of volunteer opportunity. I certify that I have and will provide information throughout the selection process, and that this information and any forthcoming, is true and accurate to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that II have not nor will not withhold any information that would unfavorably affect my application for a volunteer position.

Signature ___________________________________

Date _____________________________

For Office Use Only

Date Received __________________________

Name of Staff Person Receiving Information _______________________

Date of Interview ______________________________

Applicant: Accepted Denied

If denied, state reason ____

TOWN OF STRATFORD
VOLUNTEER PERSONNEL
(REQUIRED EVERY TWO YEARS)

Name of Person: ____

Address: ____

City: ___________________________ State:____________ Zip: ___________

This is to certify that I have examined the above named person and found him/her to be in good health and free from medical or emotional illness or disorder or addiction that would currently pose a risk to children in care or interfere with effective functioning as a volunteer in a Town sponsored program.

Signature of Physician*:_______________________ Date of Visit: _________

(Print)Name of Physician:____

Address: ____________________________ Phone Number: _______________

City: ___________________________ State:____________ Zip: ___________

*This statement may be signed by a licensed physician, advanced practice registered nurse, or physician assistant.

TOWN OF STRATFORD
RELEASE FOR BACKGROUND INFORMATION

Last Name First Name M.I.

Address

City, State, Zip

Social Security# Date of Birth

Position Applied For

In connection with my application for employment, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies, former employers, Department of Motor Vehicle and the Military Services to release information they may have about me to the person or company with which this form has been filed, or their agent, and release them from an liability and responsibility from doing so. I also authorize the procurement of an investigative consumer report and understand that it may contain information about my background, mode of living, character and personal reputation. This authorization, in original or copy form, shall be valid for this and any further reports or updates that may be requested. Further information may be available upon written request within a reasonable period of time.

Applicants Signature Date