Clatsop Care Center Health District
VOLUNTEER APPLICATION

646 16th Street
Astoria, OR 97103
Phone (503) 325-0313
Office Fax (503) 325-0115
Email info@clatsopcare.org

Date_____

First Name | MI | Last Name

Mailing Address | City | State | Zip

Employer | Position

Home Phone | Work Phone \ OK to call you at work? ☐

Email | Cell Phone

Birth date _____ Sex _____
(If you are under the age of 18, you will need to fill out a Parental Consent Form)

The information below is requested to help us better match volunteers to individual patients.

Religion | Language Skills

Education

Special interests, skills, hobbies _____

Previous volunteer experience _____

Experience with ill or dying persons _____

Please check all programs or activities you are interested in:

- ☐ Activity Aide
- ☐ CCCHD Auxiliary
- ☐ Clatsop Care Fresh Air Club
- ☐ Compassionate Companion
- ☐ Friendly Visitor
- ☐ Happy Hour Host / Hostess
- ☐ Meal Host / Hostess
- ☐ Munchies & A Movie
- ☐ Office Volunteer
- ☐ Pet Pals
- ☐ Reading Group Leader
- ☐ Room Décor & More
- ☐ Soothing Sounds
- ☐ Special Events
- ☐ Spiritual Services
- ☐ Visible Lives Storyboard Project
- ☐ Volunteer Barista

Weekday Availability (Mon-Fri) Mornings ☐ Afternoons ☐ Evenings ☐ Nights ☐

Weekend Availability (Sat-Sun) Mornings ☐ Afternoons ☐ Evenings ☐ Nights ☐

How did you learn about volunteering at Clatsop Care Center?

- ☐ Ad / flier
- ☐ Walk-in
- ☐ Returning
- ☐ Friend / family
- ☐ Other _____

Please tell us about the reason for your interest in our programs. The more information and detail that you include, the better we will be able to make decisions about how to integrate you into the program.

_____

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_____

To volunteer regularly at this facility you must consent to a T.B. screening test and a criminal background check. Do you consent to this? Yes ☐ No ☐

Emergency Information

Allergies and/or chronic health issues we should know about _____

_____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone _____ Alternate Phone _____

Physician's Name _____ Physician's Phone _____

OFFICE USE ONLY

Application Date _____ Interview Date _____ Orientation Date _____

Sign/Date when complete

Criminal Background Check _____ TB Testing _____