

WENDT CENTER  
FOR LOSS AND HEALING

VOLUNTEER APPLICATION

Please fax completed application to (202) 624-0062, Attention: Volunteer Coordinator.  
All information contained in this application will be kept strictly confidential.

Date

Last Name First Name Social Security Number

Address

City State Zip County (where applicable)

Home Phone Work Phone/Extension Mobile Phone

E-Mail Address Home Fax Work Fax

Emergency Contact Name Home Phone Work Phone/Extension

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  Trans

Ethnicity:  African American  Middle Eastern  Asian American  Native American

Caucasian  Latino/Hispanic  Other: \_\_\_\_\_

Marital Status:  Single  Divorced  Widowed  Married  Separated  Partnered

Employment:  Student  Unemployed  Retired

Status:  Full Time  Part Time Occupation: \_\_\_\_\_

Education (highest level completed):  High School  College  Post-Graduate

Field of Study: \_\_\_\_\_

Do you drive?  Yes  No

Do you have access to a vehicle you could use for volunteer assignments?  Yes  No

Do you carry automobile liability insurance?  Yes  No

\$ \_\_\_\_\_

Automobile Insurance Company Liability Limit

Please indicate if you are able to communicate *fluently* in any language in addition to English: \_\_\_\_\_

How did you first hear of the Wendt Center? \_\_\_\_\_

Do you know anyone currently working at the Center?  Yes  No If yes, whom? \_\_\_\_\_

List the organizations and dates of previous volunteer experiences.

Which of the following areas of work would be of interest to you and/ or would best utilize your skills?

Please check all that apply.

- One-on-One Support to Adult Clients
- One-on-One support to child/teen
- Volunteer Coordination
- Speaker's Bureau
- Children's Grief Camp Volunteer
- Support Groups
- Focus Group Support
- Children's Grief Camp Committee
- Research/Education
- General Office Support
- Evening or Daytime Receptionist
- Publications
- Trainings & Outreach Support
- Support Co-victims of Homicide
- Phone Support
- Public Relations/Promotion
- Annual Benefit Committee
- Fundraising
- Mailings
- Photography
- Childcare Waiting Room

Do you have any special needs we should know about?  Yes  No If yes, please explain

What are your interests and hobbies?

Have you recently experienced a loss?  Yes  No If yes, when? \_\_\_\_\_  
Please elaborate:

What is your personal and/or volunteer experience related to chronic illness?

What is your personal and/or volunteer experience related to terminal illness?

What are your sources of emotional support?

When would you be available to begin volunteering? \_\_\_\_\_

Can you make at least a one-year commitment to the Wendt Center Volunteer Program?  Yes  No

Please provide the following information for three references (one personal and two professional):

Name	Address	Phone Number
<u>Personal</u> _____	_____	_____
<u>Professional</u> _____	_____	_____
<u>Professional</u> _____	_____	_____

**Please attach a copy of your resume that highlights both your work and volunteer experience.**

**Please write a brief statement that addresses the following:**



**VOLUNTEER RELEASES/PERMISSIONS**

NAME: \_\_\_\_\_

**1. AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Should a medical emergency arise during my participation in a Wendt Center Volunteer activity and I am unable to speak for myself, I consent to:

1. the administration of medical treatments and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below and
2. the immediate administration of life-sustaining measures deemed necessary under the circumstances.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Preferred Medical Doctor/Facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Group: \_\_\_\_\_

**2. STATEMENT OF CONFIDENTIALITY**

I understand that information regarding the Wendt Center for Loss and Healing, clients and their families and/or significant others, and any persons receiving support or services in any capacity is privileged information for use by and with authorized persons only.

I will disclose such information only as part of my duties and responsibilities with the Wendt Center, or only to persons authorized to receive such information through the signed consent of patient, family member, or affected party.

I will not disclose any information with anyone unauthorized to receive this information. I will handle any and all paperwork and forms using proper procedures so that no information is accidentally observed or released to any unauthorized persons. I also understand that the casual sharing of patient care information in public places or settings is inappropriate.

**I further understand and agree that any violation of this policy is of such critical offense that it will justify my immediate discharge.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**3. LIABILITY RELEASE**

I understand and agree that the Wendt Center, its Board of Directors, Officers, and Employees, are released from any legal responsibility and/or liability due to any accidents or illnesses, which occur while I am a Wendt Center Volunteer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**4. PUBLICITY PERMISSION**

Videotaping and/or photography may occur during the course of my work as a Wendt Center Volunteer. I understand that such material may be used for future publicity by the Wendt Center. In addition, with staff permission and supervision, news media may photograph, videotape, and/or interview volunteers. I consent to having my voice and/or image recorded or photographed for use as outlined above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## VOLUNTEER CRIMINAL BACKGROUND CHECK RELEASE AND AUTHORIZATION FORM

I hereby authorize the Wendt Center for Loss and Healing or other authorized representatives of the organizations bearing this release, or copy thereof, to obtain any information pertaining to criminal and/or civil court records. I hereby direct you to release such information to the Wendt Center for Loss and Healing or other authorized representative of the organization.

I hereby fully release and discharge the Wendt Center for Loss and Healing, their employees, agents, attorney, and their respective affiliates from all claims and damages arising out of or relating to any investigations of my background for employment/ volunteer purposes.

Name: \_\_\_\_\_  
*First, Middle, Last – Print Clearly*

Current Address \_\_\_\_\_

\_\_\_\_\_  
City State Zipcode

How long at this address? \_\_\_\_\_

Previous Address (*if less than one year at above address*): \_\_\_\_\_

\_\_\_\_\_  
City State Zipcode

Other Name / Alias / Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

**Have you ever been convicted for any crime, including sex-related or child-abuse related offenses?**  No   
**Yes. If Yes, please provide detailed explanation:** (Use back of page if needed.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date