

Name: _____

Date: _____

Thank you for your interest in volunteering with the Alzheimer's Association Desert Southwest Chapter! Please answer the following questions to the best of your ability so that we can best match you with our volunteer opportunities. All information collected by the Desert Southwest Chapter is **kept strictly confidential**. We will **never** sell, trade, share or rent your personal information to any other third parties without your prior consent.

Contact Information

_____			_____		
name			date completed		
_____			_____		
address			birthdate		
_____	_____	_____	_____		
city	state	zip	email		
_____			_____		
phone (home)			phone (mobile)		

How did you hear about us?

- | | | | |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> alz assoc program | <input type="checkbox"/> health professional | <input type="checkbox"/> newspaper | <input type="checkbox"/> sign / billboard |
| <input type="checkbox"/> church / faith org | <input type="checkbox"/> internet | <input type="checkbox"/> phone book | <input type="checkbox"/> television |
| <input type="checkbox"/> community org | <input type="checkbox"/> magazine | <input type="checkbox"/> radio | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> friend / relative | <input type="checkbox"/> mass transit ad | <input type="checkbox"/> self | |

Previous Experience

Education / work experience:

Do you have previous training experience in:

- | | | | | |
|--|-------------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> clerical | <input type="checkbox"/> computers | <input type="checkbox"/> crisis intervention | <input type="checkbox"/> fundraising | <input type="checkbox"/> social services |
| <input type="checkbox"/> communication | <input type="checkbox"/> counseling | <input type="checkbox"/> education | <input type="checkbox"/> law | <input type="checkbox"/> web programming |

Other skills / training:

Do you speak languages other than English? (please list)

Previous volunteer experience:

Hobbies / personal interests:

Volunteering Information

Why are you interested in volunteering with the Alzheimer's Association?

What Alzheimer's Association job(s) are you most interested in:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Advocacy / Public Policy | <input type="checkbox"/> Health Fairs | <input type="checkbox"/> Multi-Cultural Outreach | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Clerical / Office | <input type="checkbox"/> Internet Projects | <input type="checkbox"/> Outreach Ambassador | <input type="checkbox"/> Support Group Facilitator |
| <input type="checkbox"/> Community Education | <input type="checkbox"/> Mailings | <input type="checkbox"/> Planning Committees | <input type="checkbox"/> Telephone Helpline |
| <input type="checkbox"/> Development | <input type="checkbox"/> Memory Walk | <input type="checkbox"/> Speakers Bureau | <input type="checkbox"/> Other: _____ |

What days and times are you available to do volunteer work:

- | | | | |
|-------------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Mornings | <input type="checkbox"/> Monday | <input type="checkbox"/> Thursday | <input type="checkbox"/> On Call |
| <input type="checkbox"/> Afternoons | <input type="checkbox"/> Tuesday | <input type="checkbox"/> Friday | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Evenings | <input type="checkbox"/> Wednesday | <input type="checkbox"/> Weekends | |

Do you require any special accommodations to perform your volunteer duties?

References (non relatives)

name _____	name _____
address _____	address _____
city _____ state _____ zip _____	city _____ state _____ zip _____
daytime phone _____	daytime phone _____

Emergency Contact

name _____	home phone _____
address _____	work or other phone _____
city _____ state _____ zip _____	relationship to you _____

Optional Emergency Information

medical insurance provider _____	id # _____	blood type _____
allergies _____		
medications _____		

signature _____	date _____
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