Public Health
Prevent. Promote. Protect.
Panhandle Health District

OFFICE USE ONLY
APPROVED: ________________
STATION: ________________
CHC INITIATED ____________
COMPUTER ENTRY __________

Volunteer Data Sheet and Enrollment Form

*Name on Your Driver's License ______________________________ Preferred Name ____________
*Are you known by any other name? ____

*Address ____
Street City Zip Code

Telephone __________________________ *Social Security Number ________________________

*Date of Birth ______________________ Email ____

*City and State of Birth____________________________ *Citizenship _________________________

*Height___________ *Weight ___________ *Hair Color ___________ *Eye Color ___________

*Gender ______________ Marital Status ___________________ Do you smoke? [ ] Yes [ ] No

Race/Ethnic Background:
White Asian African-American Hispanic/Latino American Indian

Are you a Veteran or active member of a branch of the military? [ ] Yes [ ] No

Are any of your family members actively serving in the military? [ ] Yes [ ] No

Physical, Visual, Hearing or Other Impairment ____

General Physical Health: [ ]Excellent [ ]Good [ ]Fair [ ]Poor

Do you own a reliable vehicle? [ ] Yes [ ] No
If not, what is your source of transportation? ____

Driver's License #___________________________ Expiration Date ____________________________

Auto Insurance Carrier ______________________ Renewal Date ______________________________

Have you ever been convicted of a crime? [ ] Yes [ ] No

Required information for Criminal History Check

Days/Hours Available: Sun Mon Tue Wed Thu Fri Sat Mornings Afternoons

Why would you like to become a Senior Companion?

____

____

Do you have any friends who are Senior Companions? [ ] Yes [ ] No

If yes, who and where did/do they serve? ____

Have you ever been a Senior Companion? [ ] Yes [ ] No

If yes, where and when did you serve? ____

Do you have any experience working with the elderly? [ ] Yes [ ] No

If yes, where and when?____

Please List any Organizations You Have Volunteered for

Organization Name ________________________________ Date(s) ______________________

Organization Name ________________________________ Date(s) ______________________

Please Answer the Following Questions

If you are accepted as a Senior Companion, do you agree to attend training and/or orientation meetings which are scheduled by the Senior Companion Program Office or the Station to which you are assigned and commit to the minimum assignment of two clients per week?

[ ] Yes [ ] No

Do you agree to follow the regulations of the Senior Companion Program as directed by the Senior Companion Project Director and the Station Lead to which you are assigned?

[ ] Yes [ ] No

The Senior Companion Program and Panhandle Health District require that any incident of elderly abuse, neglect, exploitation or potential harm be reported immediately to the Senior Companion Program office for review by the proper authorities. **Initials** _______**Date** _______

I understand that my name will be submitted for a criminal history background check as part of the interview process for the Senior Companions Program. **Initials** ________**Date** ________

A copy of your driver's license and current auto insurance card will be required if your application is approved.

As an SCP volunteer, you will be covered by accident and personal liability insurance plus a small death benefit while performing volunteer duties. This coverage is automatic and free of cost to you as long as you are an active, enrolled volunteer of SCP.

Please provide the following information:

Emergency Contact___________________________________ Phone ______________________

Beneficiary for SCP Supplemental Accident Insurance:

Name_____________________________________ Relationship__________________________
Address _______________ Phone ___________________________

Please indicate if the Senior Companion Program may have permission to use your likeness?

[ ] I hereby grant SCP permission to use my likeness in photograph(s)/video(s).

[ ] I **do not** give permission to use my likeness in photograph(s)/video(s) to SCP of North Idaho.

I, the undersigned (55+) volunteer applicant to the Panhandle Health District Senior Companion Program, understand that acceptance into the program and my continued participation is dependent upon the availability of funds, the availability of work site openings, and the approval of the SCP Project Director. I hereby certify that the statements contained herein are true and correct. I understand that any misrepresentations, falsifications or omissions will result in application denial, or if I have been accepted, termination from the Panhandle Health District Senior Companion Program. I understand that I will be serving as a volunteer and not as an employee of Panhandle Health District, the Corporation for National and Community Service, or the assigned worksite or client. I have read the statements above and by my signature acknowledge that I understand and agree to these provisions.

____ ________________________
Signature of Volunteer/Applicant Date

Completed forms should be returned to:
Senior Companions Program
c/o Panhandle Health District
8500 N Atlas Rd
Hayden, ID 83835
Phone (208) 415-5177