VOLUNTEER/TRAINEE ENROLLMENT FORM
(OAP 170-1)

NAME:____

ADDRESS:_______________________ CITY:_______________ STATE:_____ ZIP:_________

HOME PHONE:_______________ WORK PHONE:______________ COUNTY:__________________

BIRTHDATE:__________VALID DRIVERS LICENSE? Y/N ___ PRESENTLY EMPLOYED? Y/N ___

HOURS AVAILABLE PER WEEK:__________ SPECIFIC DAYS AVAILABLE:________________

ASSIGNMENT PREFERENCES

PROGRAMS:		AGE:		SERVICES:	
INTELLECTUAL DEVELOPMENTAL DISABILITIES	____	5-12	_____	TRANSPORTATION	____
BEHAVIORAL HEALTH	____	13-18	_____	TELEPHONING	____
ADDICTIVE DISEASE	____	19-40	_____	HANDICRAFTS	____
CHILD & ADOLESCENT	____	41-55	_____	HOME VISITS	____
DAY SERVICES	____	55 & up	_____	SPORTS ACTIVITIES	____
GROUP	____			WORK ACTIVITIES	____
INDIVIDUAL	____			OUTSIDE ACTIVITIES	____
				CONSULTATION/EDUCATION	____
				CLASSROOM ACTIVITY	____
				GROUP ACTIVITIES	____
				OTHER	____

EDUCATION LEVEL (YEARS): ____

TOTAL YEARS OF VOLUNTEER/TRAINEE EXPERIENCE: _________________________________

TYPE OF EXPERIENCE: ____

PHYSICAL LIMITATIONS: ____

SPECIAL SKILLS: ____

PROFESSIONAL LICENSE: ____

DATE OF RENEWAL OF PROFESSIONAL LICENSE: _____________________________________

Complete: **VOLUNTEER/TRAINEE ENROLLMENT FORM** and provide a current Criminal Background Check and current results from a TB Skin test to the CSB of Middle Georgia Personnel Department and arrange an appointment with personnel for a drug screening. Prior to being enrolled as a volunteer at CSBMG you will also be asked to complete a **VOLUNTEER REGISTRATION AND LIABILITY INSURANCE COVERAGE APPLICATION**.
NOTE: Volunteers are responsible for the cost of any background checks, TB Skin Tests, and drug screens.