

VOLUNTEER APPLICATION

Available start date: ____/____/____

Personal information

Mr. Mrs. Ms. Miss Preferred Pronouns: _____

First name: _____ Last name: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Preferred phone: _____ mobile home

Email: _____ @ _____ . _____

Preferred method of contact: Postal Mail Phone E-mail

Are you 18 years of age or older? Yes No Date of Birth: MM DD YYYY

Current employer or school: _____ Position or grade level: _____

Are you retired? Yes No

How did you hear about our volunteer opportunities?

Alzheimer's Association education program Alzheimer's Association employee

VolunteerMatch.com LinkedIn alz.org Google

Individual: _____

Student group or company: _____

Other: _____

Have you ever been employed by or volunteered for this or any Alzheimer's Association office? Yes No

Chapter Name: _____ Position: _____ Dates: _____

What volunteer opportunities are you interested in learning more about? Please check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Community educator | <input type="checkbox"/> Community representative | <input type="checkbox"/> Community volunteer leader |
| <input type="checkbox"/> Promotor/promotora | <input type="checkbox"/> Program committee | <input type="checkbox"/> Faith outreach volunteer |
| <input type="checkbox"/> Social engagement leader | <input type="checkbox"/> Support group facilitator (caregiver or early-stage) | <input type="checkbox"/> Advocate/Alzheimer's Congressional Team member |
| <input type="checkbox"/> Walk to End Alzheimer's® committee | <input type="checkbox"/> Walk to End Alzheimer's® event day assistant | <input type="checkbox"/> The Longest Day® committee |
| <input type="checkbox"/> Development committee | <input type="checkbox"/> Advisory board | <input type="checkbox"/> Office volunteer |
| <input type="checkbox"/> Group opportunities | | |

Emergency Contact Information

Name: _____

Relationship: _____ Phone: _____

References

1. Name: _____

Email: _____ @ _____ . _____

Years Known: _____ Phone: _____

Relationship: _____

2. Name: _____

Email: _____ @ _____ . _____

Years Known: _____ Phone: _____

Relationship: _____

Signing this application attests that all information on this application is accurate to my knowledge and consents to allow the Alzheimer's Association, Central New York Chapter to contact my references.

I understand that in order to become a volunteer for the Alzheimer's Association, Central New York Chapter that I may be required to undergo a background check, disclose any conflicts of interest, participate in an on-boarding orientation as well as ongoing trainings to prepare me for my assignment(s). Furthermore, I will abide by all policies and procedures as written in the Volunteer Handbook.

Printed Name: _____

Signature: _____

Date: _____

Please send completed application to:

Alzheimer's Association
ATTN: Volunteer & Outreach Coordinator
441 W. Kirkpatrick St.
Syracuse, NY 13204

or email it to **cny-volunteer@alz.org**

FOR OFFICE USE ONLY

Received: ____/____/20____

Entered into R/E: ____/____/20____

V&O Coordinator Approved:
