VOLUNTEER APPLICATION
CATHOLIC CHARITIES LONG TERM CARE OMBUDSMAN PROGRAM

PERSONAL INFORMATION

NAME: ____
Last First Middle

PRESENT ADDRESS: ____
Street City State Zip

PHONE: (______) ____________________ **E-MAIL:** ____________________

PRESENT OR PRIOR EMPLOYMENT: **Are you presently employed?** ____________

Name of Employer: ____________________ **Position:** ____________

EDUCATION: **Highest grade level or degree attained** ____________________

REFERENCES: **(Give the names of three persons not related to you, whom you have known for at least one year)**

NAME	ADDRESS	HOME PHONE	WORK PHONE	YRS KN

Time Commitment

Can you make a one-year commitment to the Ombudsman Program? ____________________

Is there anything that might interfere with your ability to volunteer in the future such as employment, travel, family obligations, moving? __________ If yes, please explain: ____

____

Can you visit the facility for one hour:
At least once a week? ____________ At least once every two weeks? ____________

Are you willing to submit written reports? ____________

Will you be available to attend and complete the Ombudsman training during normal business hours? If not, when are you available? ____

I hereby certify that all statements in this application are true and correct to the best of my knowledge and understand that falsification of information shall be grounds for termination of my volunteer position. I authorize Catholic Charities Long Term Ombudsman Program to contact listed references.

I understand that I must be officially accepted before beginning my volunteer position. I agree to fulfill the responsibilities of this volunteer position to the best of my ability. I understand that failure to comply with the information as provided in the Illinois Department on Aging manual may lead to decertification.

Signature ____________________ Date ____________