



VOLUNTEER APPLICATION

Volunteer's Name (Last) _____ (First) _____

Other Last Name/*Maiden _____

SSN # _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ Other: () _____

Email Address _____ Sex: Male Female

T-shirt size: S M L XL XXL

Medical License: MD DO PA RN NP RT CRTT PharmD Paramedic Other _____

Occupation/Position _____ Employer _____

Employer's Address _____ City _____ Zip Code _____

Number of Years in Profession _____

Do you have experience working in asthma? Yes No

If yes, please explain _____

Please circle any certifications you currently hold: CPR ACLS First Aid PALS

PLEASE SUBMIT A COPY OF YOUR MEDICAL LICENSE AND CPR CARD WITH THIS APPLICATION IN ORDER FOR IT TO BE PROCESSED

What days are you interested in volunteering?

(We must ask for a minimum commitment of 3 ½ days to ensure continuity of care for the children.)

- May 30 – June 5, 2009 (Full Week)
- May 30 – June 2, 2009 (Saturday – Tuesday)
- June 2-5, 2009 (Tuesday – Friday)

Would you be interested in riding the bus with the children to and from camp? Yes No

Have you ever been convicted of a criminal offense? _____ If yes, please explain _____

Do you use illegal drugs? _____

Have you ever been convicted of child neglect or abuse? _____

Other than the above, is there any fact or circumstance involving you or your background that would call into question your being entrusted with the supervision, guidance, and care of young people? _____

If yes, please explain _____

What gender and age group would you prefer to work with? _____

Would you be interested in precepting a student? Yes No

Would you be interested in receiving an asthma overview prior to camp? Yes No

If I am accepted as a volunteer at Camp Not-A-Wheeze, I understand that my room/board and participation in all activities is included as a volunteer. I further understand that no monetary or material compensation will be made for my time.

*I understand that I will be asked to either teach or assist in teaching daily asthma education sessions. I further understand that the asthma education curriculum will be provided for me by the **American Lung Association of Arizona**.*

I hereby acknowledge the risk involved in a camp environment and I release Friendly Pines Camp, the American Lung Association of Arizona and all camp sponsors, their incorporators, board members, officers, employees, agents, independent contractors and volunteer/contract workers from any liability for injuries, emergencies, or other problems occurring during camp.

I consent to be photographed or videotaped for the purpose of recording the camp experience. I understand that these photographs or tapes may be used for publicity, fundraising or other purposes by the sponsoring organizations and I do not expect monetary or material compensation for their use.

***Background checks will be conducted on all volunteers.**

Information obtained will be kept confidential.

Signature

Date

Printed Name

Please return application as soon as possible to :

**American Lung Association of Arizona
Attn: Kelly Szymanski
102 W McDowell Road
Phoenix, AZ 85003**

Questions? Call (602)258-7505 or 1-800-586-4872



VOLUNTEER INFORMATION

Please Print Clearly

Name (Last) _____ (First) _____

Other Last Name/*Maiden _____

Address _____

City _____ State _____ Zip Code _____

Home Phone: () _____ Work Phone: () _____

Date of birth: ____ / ____ / ____ S.S # _____

EMERGENCY CONTACT(S)

Name _____ Relationship _____

Home Phone: () _____ Work Phone: () _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____ Work Hours _____

Name _____ Relationship _____

Home Phone: () _____ Work Phone: () _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____ Work Hours _____

HEALTHCARE INFORMATION

Name of Medical Insurance Company _____

Policy Number _____

Physician's Name _____

Physician's Address _____

Physician's Phone () _____

