

Date:

**VOLUNTEER SERVICE APPLICATION**

\*optional

NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

HOME PHONE: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

PLACE OF BUSINESS: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

\*MARITAL STATUS: \_\_\_\_\_ \*BIRTHDATE: \_\_\_\_\_ \*AGE: \_\_\_\_\_

\*NUMBER OF CHILDREN: \_\_\_\_\_ \*AGES: \_\_\_\_\_

\*ETHNIC BACKGROUND: \_\_\_\_\_ \*CHURCH AFFILIATION: \_\_\_\_\_

\*EDUCATION - Highest Grade or Degree Completed: \_\_\_\_\_ Where: \_\_\_\_\_

\*If pursuing a degree, in what field: \_\_\_\_\_

DO YOU HAVE TRANSPORTATION AVAILABLE? \_\_\_\_\_

HAVE YOU DONE VOLUNTEER SERVICE BEFORE? \_\_\_\_\_ WHERE? \_\_\_\_\_

FOR HOW LONG? \_\_\_\_\_ WHAT? \_\_\_\_\_

PLEASE STATE ANY FOREIGN LANGUAGES YOU MAY SPEAK: \_\_\_\_\_

WHAT TYPE OF VOLUNTEER SERVICE ARE YOU INTERESTED IN?

(1) Mentor: Child \_\_\_\_\_ (3) Clerical \_\_\_\_\_ (5) PARA - ESL \_\_\_\_\_

I am available for a 6 mos. to 1 year commitment  Yes  No

(2) Tutor \_\_\_\_\_ (4) Transporter \_\_\_\_\_ (6) Other \_\_\_\_\_

I am available for the school year  Yes  No

SPECIAL SKILLS OR TALENTS: \_\_\_\_\_

PLEASE LIST THREE REFERENCES WHO RESIDE IN THE UNITED STATES, WHO HAVE KNOWN YOU FOR AT LEAST ONE YEAR, AND WHO ARE NOT RELATED TO YOU. YOU MUST INCLUDE THEIR PHONE NUMBER, AS WELL AS THEIR FAX NUMBER or E-MAIL: (If possible, please provide one employer reference.)

1. \_\_\_\_\_  
(Name) (Phone Number) (Fax Number) OR (E-mail)

2. \_\_\_\_\_  
(Name) (Phone Number) (Fax Number) OR (E-mail)

3. \_\_\_\_\_  
(Name) (Phone Number) (Fax Number) OR (E-mail)

I authorize Bethany Christian Services to investigate my past work or school record and performance. I release all employers, schools, or person supplying such information from all liability arising out of their response to such investigation.

**On the back of this application, please briefly explain why you are interested in volunteering at Bethany and include any important experiences or facts about yourself that will help us to better understand who you are.**

Applicant's Signature: \_\_\_\_\_

I, the undersigned, authorize the Department of State Police, Central Records Division, and local police, to conduct a criminal history file by name and identifiers to determine the existence of any arrest resulting in conviction. I, the undersigned, also authorize Bethany Christian Services to submit a request for my driving record in order to comply with state and accreditation regulations.

**BETHANY CHRISTIAN SERVICES**

Today's Date: \_\_\_\_\_

Print Full Name with Middle Initial: \_\_\_\_\_

Race: \_\_\_\_\_

Signature: \_\_\_\_\_

Previous Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_

**MEDICAL REPORT FOR VOLUNTEERS**

**Significant Health History**

**Please indicate if you have had any of the following conditions and when.**

	<b>Dates</b>		<b>Dates</b>
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Allergy</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Epilepsy</b> _____
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Asthma</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Heart Disease</b> _____
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Cancer</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Kidney Disease</b> _____
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Cerebral Palsy</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Meningitis</b> _____
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Convulsions</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Psychological or Nervous Disorders</b> _____
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Depression</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Tuberculosis</b> _____
<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Diabetes</b> _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<b>Closed Head Injuries or Tumors</b> _____

**If you have checked "yes" to any of the above, please provide dates.**

**On the back of this form, please list other significant medical history, such as: counseling, operations, trauma, hospitalizations, and any medications you may be taking that would alter your moods.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# REQUEST FOR CENTRAL REGISTRY CLEARANCE

State of Michigan  
Michigan Department of Human Services

**INSTRUCTIONS:** Complete the following information and submit request to your **LOCAL** Department of Human Services (DHS) Office. See [www.michigan.gov/canregistryclearance](http://www.michigan.gov/canregistryclearance) for information on central registry clearance requests and how to contact the local DHS office.

I am requesting that DHS provide me with a Central Registry Clearance on myself.

Today's Date		
Name		
Birthdate	Social Security Number	
Current Mailing Address (Street No. and Name)		
City	State	Zip Code
Current Phone Number		
Other Names By Which Known		
_____		
_____		

**Indicate below how you want to receive the results of the central registry clearance:**

I would like the results mailed to the address on my picture identification.

**IF YOU WANT THE RESULTS MAILED TO YOU, PLEASE SUBMIT ALONG WITH THIS FORM, A COPY OF YOUR CURRENT PICTURE IDENTIFICATION. DUE TO CONFIDENTIALITY RESTRICTIONS, A COPY OF THE RESULTS WILL BE MAILED ONLY TO THE ADDRESS ON YOUR PICTURE IDENTIFICATION.**

I would like to pick up the results from the local DHS office.

**IF YOU ARE TEMPORARILY IN MICHIGAN AND THE ADDRESS ON YOUR PICTURE IDENTIFICATION AND YOUR TEMPORARY ADDRESS DO NOT MATCH, YOU MUST CHOOSE THIS OPTION.**

I would like the results mailed to:

Employer/Potential Employer

Volunteer Agency

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IF YOU ARE LISTED ON CENTRAL REGISTRY, THE RESULTS CANNOT BE MAILED TO AN EMPLOYER/POTENTIAL EMPLOYER OR VOLUNTEER AGENCY. RESULTS WILL BE MAILED TO YOU INSTEAD. A COPY OF YOUR CURRENT PICTURE IDENTIFICATION MUST BE PROVIDED.**

Signature of Requestor	Signature of DHS Staff Person Completing Request
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AUTHORITY: State P.A. 238 of 1975, MCL 722.627-722.627j RESPONSE: Voluntary PENALTY: Inappropriate release of this information is a misdemeanor.	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
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