Between Ages Adult Social Center

"Where Comfort and Stimulation Never End"

Phone: (914)-740-5160 | **Email:** daycare@betweenages.com
Fax: (914)-740-5161 | **Website:** www.betweenagesasc.com
175 Memorial Highway, Suite 1-3, New Rochelle, NY, 10801

VOLUNTEER APPLICATION

Between Ages Adult Social Center is an equal opportunity organization. This application will not be used to limit or exclude any applicant from participation based on any status protected by local, state, or federal law.

APPLICANT INFORMATION

- **Name:** _____
- **Address:** _____
- **Date of Birth:**
- **Telephone:**
- **Social Security Number (optional or if required for background checks):** _____
- **Date Available to Begin Volunteering:**

VOLUNTEER POSITION

- **Position(s) Applying For:**
  ☐ Director ☐ Activity Leader ☐ Registered Nurse ☐ Driver ■ Social Worker ☐ Public Relations Worker ☐ Office Clerk ☐ Administrative Assistant
- **How did you hear about this volunteer opportunity?**
- **What days are you available to volunteer?**
- **What hours or shifts are you available?**
- **If needed, are you available to volunteer extra hours or on short notice?**
  ☐ Yes ☐ No
- **Do you have reliable transportation to and from the volunteer site?**
  ☐ Yes ☐ No

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LIGIBILITY & BACKGROUND INFORMATION

- **Are you 18 years of age or older?**
  ☐ *Yes* ☐ *No*
- **Are you a U.S. citizen or otherwise authorized to volunteer in the United States?**
  ☐ *Yes* ☐ *No*
- **If yes, which documents can you provide as proof of status?** _____
- **Will you consent to a controlled substance screening if required for your role?**
  ☐ *Yes* ☐ *No*
- **Have you ever been convicted of a criminal offense (felony or misdemeanor)?**
  ☐ *Yes* ☐ *No*

If yes, please explain (include nature of offense, date, location, and outcome):

SKILLS & QUALIFICATIONS

Please list any relevant skills, certifications, or qualifications you have for the position(s) you're applying for:

_____

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EDUCATION & TRAINING

- **School Name:**
  - Degree/Program: _____
  - Graduation Date: _____

MILITARY SERVICE (if applicable)

- **Are you a veteran or currently serving in the Armed Forces?**

- **Branch of Service:**
- **Rank at Discharge:**
- **Years of Service:**
- **Relevant skills or training that would support your volunteer role:**

VOLUNTEER OR WORK EXPERIENCE

Please list your most recent relevant experience:

1. Organization Name:

- Role/Title:
- Supervisor Name:
- Address:
- Phone Number:
- Dates of Involvement:
- Reason for leaving or ending service:

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2. Organization Name:

- Role/Title:
- Supervisor Name:
- Address:
- Phone Number:
- Dates of Involvement:
- Reason for leaving or ending service:

3. Organization Name:

- Role/Title:
- Supervisor Name:
- Address:
- Phone Number:
- Dates of Involvement:
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REFERENCES

Please provide at least one professional or personal reference:

Name Relationship Phone Email

ADDITIONAL INFORMATION

Please include any additional details or information you feel would support your application:

AT-WILL VOLUNTEER STATEMENT

Your relationship with Between Ages Adult Social Center is considered **at-will**, meaning that either you or the organization may end the volunteer arrangement at any time, with or without cause or notice. No representative of Between Ages Adult Social Center has the authority to change this relationship, unless in a written agreement signed by both you and the Executive Vice President/Chief Operations Officer or the President.

Applicant Signature: _____

Date: _____

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VOLUNTEER HEALTH EXAMINATION

REPORT PERSONAL DATA

_____ Last Name _____ First Name

Gender: Male ⬜ Female: ⬜ Weight ____ Height ____

Date of birth ____ / ____ / ____

Medical History

Medical Condition/s _____

Epilepsy _____

Substance Abuse _____

Mental illness/es _____

Rubella status _____ Measles status _____

Hepatitis B status _____

1) Mantoux Test P.P.D. Date _____ Result _____
2) Chest X-Ray Date _____ Result _____

Is he or she approved for employment in an Adult Daycare Center? Yes⬜ No⬜

If no, explain _____

Doctor's

Name: _____ Telephone contact: _____

Address: _____ Signature: _____

License: _____ Date: _____

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Covid-19 Test Result: Positive⬜ Negative⬜ (If the patient is not vaccinated against COVID-19, please answer.)

Doctor's

Name: _____ Telephone contact: _____

Address: _____ Signature: _____

License: _____ Date: _____