LOCAL HELP FOR PEOPLE WITH MEDICARE

Senior Health Insurance Assistance Program (SHIP) & Senior Medicare Patrol (SMP) Volunteer Application

(Please type or print)

Name____ Date____________________

Address__________________________________City___________________State__________

Zip________ Email___________________________________ Cell Phone___________________

Telephone (Home)__________________Telephone (Work)____________________________

Date of Birth: Month ______ Day ______Year______________

Demographic Information:

Race _____White _____African American _____Asian

_____American Indian/Alaskan ____Hawaiian Pacific Islander _____2 or more races

Ethnicity

_____Hispanic _____Non Hispanic _____Unknown

Emergency Contact Information:

Name: ____________________________ Telephone____________________

Relationship to Volunteer_________________

Volunteer Interests/Availability: (Please designate first and second choice.)

____Marketer ____Administrative Assistance ____Community Presentations/Outreach

____Screener _____Counselor _____SMP Assistant

What days and times would you be available to volunteer?__________________________________

Background/Interests:

What would you like to get out of your volunteer experience?_________________________________

Please list your experience with Medicare/Health Insurance___________________________________

Where did you hear about volunteering with the Bureau of Aging & Disabilities?____

What level of education have you completed?

____

Languages Spoken____

Employment Information: (please check one):
I am: _____Employed _____Retired _____Student

Current School / Occupation _____________________________________Full time___ Part time___

References:
Please list at least two people as personal references who are not related to you and have known you for at least one year

Name______________________________________Phone_____________________________

Name______________________________________Phone_____________________________

As a Carroll County volunteer, the lasting impression you make on those you serve reflects directly on all of us. Please be sure your words and deeds will help build our program and its reputation for quality.
I, ______________________ agree to perform the volunteer duties to which I am assigned to the best of my ability and in a professional manner.
I understand that as a volunteer, authorized by the SHIP Program Coordinator, I am afforded liability protection with respect to damages to third parties to the same extent as county employees, as long as I am acting within the scope of my duties as a volunteer. I understand that there are inherent dangers in any workplace activity or program. Carroll County assumes no liability for injury to myself or damage to my personal property unless caused by the negligence of the County. I hereby certify that the information provided above is true and complete to the best of my knowledge.

I/we hereby release and hold harmless Carroll County, Maryland, its officials, agents and employees from liability or obligation arising from, or in connection with my volunteer activities.

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Signature: Volunteer Applicant Date