

Volunteer Application



Our Mission

To unite with Alaskans affected by Alzheimer's disease and related disorders to ensure quality of life until a cure is found.

Thank you for your interest in the Alzheimer's Disease Resource Agency of Alaska volunteer program. The secure information you provide on your application is for internal use only and for the sole purpose of matching applicants with suitable positions.

After reviewing your application, we will contact you to set up a mutually convenient time to meet to discuss your skills, interests and time availability and the various options available to find a satisfactory and rewarding position.

Applicant

Name: _____
 First M.I. Last

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Day Phone: _____ Evening Phone: _____

Best time to call: _____

Date of birth: _____ Gender: M F Education: _____

Ethnicity: _____ Languages spoken: _____

Emergency Contact

Name: _____

Phone: _____

References

1. Name: _____
 First M.I. Last

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

2. Name: _____
 First M.I. Last

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

3. Name: _____
 First M.I. Last

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Skills and Experience

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Art/Graphic Design | <input type="checkbox"/> Event Planning | <input type="checkbox"/> Photography | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clerical | <input type="checkbox"/> Finance | <input type="checkbox"/> Public Speaking | _____ |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Health Care | <input type="checkbox"/> Public Relations | _____ |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Interpretation | <input type="checkbox"/> Spiritual Care | _____ |
| <input type="checkbox"/> Education | <input type="checkbox"/> Legal | <input type="checkbox"/> Writing | _____ |

Possible Assignments

Please check the areas you are interested in.

- | | | | |
|---|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Facility Maintenance | <input type="checkbox"/> Interpreter | <input type="checkbox"/> Photographer |
| <input type="checkbox"/> Fundraising events | <input type="checkbox"/> Health Fairs | <input type="checkbox"/> Office work | |

Hours you can commit to volunteering:

- Weekly: _____ Monthly: _____ Special Projects: _____ Other: _____

Volunteer Expectations

Why do you want to volunteer with the Alzheimer's Resource of Alaska?

What do you expect to gain from your experience working with us?

CONFIDENTIALITY POLICY

I, _____, serving as an employee, contractor, volunteer, and/or student intern for the Alzheimer's Disease Resource Agency of Alaska, Inc., have taken an oath of confidentiality and agree to the following:

In my position at the Alzheimer's Disease Resource Agency of Alaska, Inc., I promise to uphold the principle of ethics set forth by the Agency and never disclose information about a client, family, or donor without the written consent of the client, family or donor. This information includes the identity of the client, family or donor; content of conversations, content of professional opinions about the client, family or donor; or materials about the client, family or donor. If information needs to be exchanged with the Agency staff, it will be on a need-to-know basis and only include facts and never involve gossip or hearsay. At no time will I discuss a client, family or donor in public or private conversations.

The Health Insurance Portability and Accountability Act's (HIPPA) "Minimum Necessary" portion of the Privacy Notice supports the above statements.

Signature of Volunteer

Printed Name of Volunteer

Date and Time

Send to: 1750 Abbott Rd., Anchorage, AK 99507 or fax to: (907) 561-3315