Western Illinois Area Agency on Aging an Aging and Disability Resource Center
Phone: (309) 793-6800/FAX (309) 793-6807
www.wiaaa.org

Volunteer Application

Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Volunteer Opportunities (*check all that apply*)
☐ Senior Health Insurance Program (SHIP)
☐ Senior Medicare Patrol (SMP)
☐ Matter of Balance (MOB)
☐ Other, please list: _____

Employment Experience (briefly describe):

_____

Describe training, special skills, hobbies and/or interests:

_____

Please indicate days available: Monday Tuesday Wednesday Thursday Friday

Times Available: From _____ to _____

Length of Commitment:

☐ Less than six months
☐ More than six months
☐ Other, please explain: _____

I understand that a successful FBI background check is a condition of volunteering at Western Illinois Area Agency on Aging and agree to provide the information necessary to complete the background check ☐ Yes ☐ No

Western Illinois Area Agency on Aging an Aging and Disability Resource Center
Phone: (309) 793-6800/FAX (309) 793-6807
www.wiaaa.org

Please list three references:

1. Name: _____ Phone: _____

Address: _____ Years Known: _____

2. Name: _____ Phone: _____

Address: _____ Years Known: _____

3. Name: _____ Phone: _____

Address: _____ Years Known: _____

Mail your completed application to 729 34th Ave., Rock Island, IL 61201

Thank you for your interest in volunteering!