



Volunteer Application And Release of Liability

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 sderstine@canetwork.org

Today's Date:

PERSONAL INFORMATION

Full Name:	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Bilingual? <input type="checkbox"/> Y or <input type="checkbox"/> N Languages:
Address:	City:	State:	ZIP:
Home Phone:	Cell:	Email:	
Church Membership or Affiliation:	Have you ever been convicted of a <input type="checkbox"/> felony or <input type="checkbox"/> misdemeanor? If Yes, Please Explain:		

Volunteering Information CSW___ #Hours___

How did you hear about Cornerstone? <input type="checkbox"/> Web <input type="checkbox"/> Friend _____ <input type="checkbox"/> Church <input type="checkbox"/> Staff Member _____ <input type="checkbox"/> Client <input type="checkbox"/> Other _____	What days are best for you to volunteer? <input type="checkbox"/> Mon. <input type="checkbox"/> Tue. <input type="checkbox"/> Wed. <input type="checkbox"/> Thur. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat. -Medical Clinic Volunteers Only Please let us know if you have any physical limitations.
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Volunteers are encouraged to try a variety of areas of service to find the best match for their interests and skill sets. Please let us know which of the following areas you would like to know more about:

<input type="checkbox"/> Administrative Assistance	<input type="checkbox"/> Reentry First Stop-Admin Assistance*
<input type="checkbox"/> Dental Clinic-Dentist, Hygienist, or Assistant	<input type="checkbox"/> Receptionist – Admin Reception
<input type="checkbox"/> Medical Clinic- Doctor*	<input type="checkbox"/> Receptionist – Welcome Center
<input type="checkbox"/> Medical Clinic- Nurse*	<input type="checkbox"/> Thrift Store (sort donated items) - No Saturdays
<input type="checkbox"/> Medical Clinic- Student*	<input type="checkbox"/> Other- _____
<input type="checkbox"/> Medical Clinic- Translator*	

*Background Check Required

Please list two references that are not related to you.

1. Name _____ Address _____ Phone _____
Email _____ Relationship _____
2. Name _____ Address _____ Phone _____
Email _____ Relationship _____

Emergency Contact

Name _____ Relationship _____
Primary Phone Number _____ other phone _____

Please read and Initial Each Statement, then Sign Below

___ I verify that the above information is complete and accurate.

___ I will hold all information regarding Cornerstone Assistance Network clients to the utmost confidentiality.

___ By volunteering for CAN, I acknowledge and expressly agree that any unresolved claim or dispute arising out of any Accident or Occurrence will be resolved exclusively through alternative dispute resolution procedures, or other legal process. The arbitrator shall issue a written decision and award, if any, stating the reasons therefore. The decision and any award shall be final and binding. No contractual relationship is hereby created other than this agreement to arbitrate.

___ Cornerstone Assistance Network staff members have permission to utilize any photographs or videos taken of me for publicity or training purposes.

___ I give permission to Cornerstone Assistance Network to contact the provided references.

___ I give permission to Cornerstone Assistance Network to contact me by email.

Printed Name _____

Signature _____ Date _____

Signature of Guardian if under 18 _____

For Office Use Only								
Background Check Requested		Yes	No	Background Check Cleared		Yes	No	Date _____
References Checked			Assigned to _____ & _____				Date _____	
Yes	No	N/A	Program:					
Notes: _____								
___ Donor Perfect		___ Sales Force		___ CAN Connection		Rev. 07.12.23		