

Who referred you to our agency _____

What skills or interest do you have to share? _____

Previous volunteer experience _____

EMPLOYMENT HISTORY

PLEASE LIST YOUR LAST TWO EMPLOYERS, ASSIGNMENTS, MILITARY EXPERIENCE, OR VOLUNTEER ACTIVITIES. BEGIN WITH YOUR MOST RECENT OR CURRENT EMPLOYER

Employer/Company Name _____

Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Date started _____ Date ended _____

Immediate Supervisor _____ Your Job Title _____

May we contact them for a reference? YES NO LATER

Summarize the nature of the work performed and job responsibilities: _____

Reason for leaving _____

Employer/Company Name _____

Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Date started _____ Date ended _____

Immediate Supervisor _____ Your Job

Title _____

May we contact them for a reference? YES NO LATER

Summarize the nature of the work performed and job responsibilities: _____

Reason for leaving _____

Please list 3 **PERSONAL** references (not immediate supervisors or relatives) with their **COMPLETE PHONE NUMBER AND MAILING ADDRESS**:

Name _____
Phone _____
Mailing Address _____
City _____ State ____ Zip ____
Relationship _____ Years Known _____

Name _____
Phone _____
Mailing Address _____
City _____ State ____ Zip ____
Relationship _____ Years Known _____

Name _____
Phone _____
Mailing Address _____
City _____ State ____ Zip ____
Relationship _____ Years Known _____

Confidentiality: Consumers may confide in you from time to time. Volunteers should treat these concerns confidentially. If you are aware of problems which may require action, please call the Cerebral Palsy office as soon as possible. Volunteer feedback in the way of information is important to the growth and success of our agency.

INFORMATION WAIVER

Your signature below certifies that the information given on this application is correct and complete.

Falsification of or failure to provide complete and accurate information on this application will result in immediate termination of employment.

CEREBRAL PALSY OF MIDEAST WISCONSIN will make a reasonable investigation of the information provided in this application. Your signature below authorizes CEREBRAL PALSY OF MIDEAST WISCONSIN to make any reasonable inquiries triggered by the information provided in this application. In this connection, you agree to release from liability any individual who provides information to CEREBRAL PALSY OF MIDEAST WISCONSIN in response to such an inquiry.

Signature

Date