diabetes education
CENTER OF THE MIDLANDS

DECM VOLUNTEER ENROLLMENT FORM

Name:_____ Phone: (H)_____(O) _____

Address:_____ email _____

City: _____ State:_____Zip:_____

Emergency Contact: _____ Phone:_____

I. SKILLS AND INTERESTS

Hobbies, Interests, Skills:_____

Previous Volunteer Experience: _____

IS THERE A PARTICULAR TYPE OF VOLUNTEER WORK IN WHICH YOU ARE INTERESTED? (Check all that apply)

☐ Preparing information packets for class ☐ General office duties: mailing, filing, data entry ☐ Photocopying ☐ Knowledgeable in Excel__ Word__ 10 key__	☐ Telephone calls: follow-ups, reminder calls to patients and volunteers ☐ Serve on Committee for planning & executing events ☐ Special Events: Health fairs ____ Annual Seminar ____ Annual Open House ____ ☐ Other: _____

PLEASE SPECIFY ANY PHYSICAL/MEDICAL LIMITATIONS: _____

II. AVAILABILITY

AT WHAT TIMES ARE YOU INTERESTED IN VOLUNTEERING?

☐ I am flexible ☐ Prefer Weekdays ☐ Prefer evenings ☐ Prefer weekends

☐ Specific day (s) _____ ☐ Specific hours _____

III. REFERENCES

HOW DID YOU HEAR ABOUT US? ☐ Newspaper ☐ Referred by Staff ☐ Internet ☐ Other Agency

☐ Referred by current volunteer ☐ Other _____

LIST NAME AND PHONE NUMBERS OF TWO PERSONAL REFERENCES:

Name_____Address_____Phone_____

Name_____Address_____Phone_____

Signature of Applicant_____ Date _____

If under 18 years of age, signature of parent/guardian required

Signature of Parent/Guardian_____ Date _____

Please return this form to: DECM, 2910 South 84th Street, OMAHA, NE 68124
402-399-0777 Fax (844)763-9353
patientservices@diabetes-education.com