

Date of Application: \_\_\_\_\_

# PROSPECTIVE VOLUNTEER PROFILE

UNITE: PO BOX 7, CASTLE ROCK, WA, 98611

[www.cr-cc.org](http://www.cr-cc.org) TEL: 360.274.6771 EXT. 24

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

\_\_\_\_\_ ZIP: \_\_\_\_\_

EMAIL: \_\_\_\_\_

HOME: \_\_\_\_\_ CELL: \_\_\_\_\_

BEST TIME TO CALL (CIRCLE): MORNING AFTERNOON EVENING

YOUTH MINISTRY EXPERIENCE: \_\_\_\_\_

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FOR WHICH POSITION ARE YOU VOLUNTEERING? WHY?: \_\_\_\_\_

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ARE YOU A BAPTIZED BELIEVER? \_\_\_\_\_

HOW CAN WE BE PRAYING FOR YOU? \_\_\_\_\_

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Date of Application: \_\_\_\_\_

**EMERGENCY CONTACT:**

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PHYSICIAN'S NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PREFERRED MEDICAL FACILITY:** \_\_\_\_\_

**INSURANCE Co.:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**SUBSCRIBER #:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_

**ALLERGIES, CURRENT MEDS:** \_\_\_\_\_

**CONSENT: IN THE EVENT EMERGENCY MEDICAL AID/TREATMENT IS REQUIRED DUE TO ILLNESS OR INJURY WHILE PARTICIPATING IN THE MINISTRY OF UNITE, I AUTHORIZE FOR UNITE PAID OR VOLUNTEER STAFF TO:**

- 1. SECURE AND RETAIN MEDICAL TREATMENT AND TRANSPORTATION IF NEEDED**
- 2. RELEASE CLIENT RECORDS UPON REQUEST TO THE AUTHORIZED INDIVIDUAL OR AGENCY INVOLVED IN THE MEDICAL EMERGENCY TREATMENT**

**THIS AUTHORIZATION INCLUDES X-RAY, SURGERY, HOSPITALIZATION, MEDICATION, AND ANY TREATMENT PROCEDURE DEEMED "LIFE SAVING" BY THE PHYSICIAN. THIS PROVISION WILL ONLY BE INVOKED IF THE PERSON(S) LISTED ABOVE ARE UNABLE TO BE REACHED.**

**DATE:** \_\_\_\_\_ **CONSENT SIGNATURE:** \_\_\_\_\_  
(PARENT/GUARDIAN IF UNDER 18)

**NON-CONSENT: I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT/AID IN THE CASE OF ILLNESS/INJURY WHILE PARTICIPATING IN THE MINISTRY OF UNITE. IN THE EVENT EMERGENCY TREATMENT/AID IS REQUIRED, PLEASE FOLLOW THESE PROCEDURES:**

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\_\_\_\_\_  
\_\_\_\_\_

**DATE:** \_\_\_\_\_ **NON-CONSENT SIGNATURE:** \_\_\_\_\_  
(PARENT/GUARDIAN IF UNDER 18)