



Name _____
D.O.B. _____
Address _____
Email _____ Phone # _____
Present Occupation _____ Employer _____
Education and Training _____

Volunteer Experience _____

Have you ever worked or volunteered in a health or childcare setting? Yes__ No__

If yes, please describe _____

Your physician's name and address (please include complete mailing address) _____

Have you ever been convicted of a crime other than a traffic violation? Yes__ No__

If yes, please describe _____

Hobbies, special interests or skills, memberships (church, civic, etc.) _____

Personal references (please include one family member) with mailing addresses

1. _____ 2. _____ 3. _____

Phone _____ Phone _____ Phone _____

Days available to volunteer _____

Times available to volunteer _____

What volunteer opportunities are you interested in at CDS? Why? _____

Emergency contact (Name and relationship) _____

Address _____

Phone (Cell, home, work) _____

I certify that answers given herein are true and complete to the best of my knowledge. I hereby give the Center for Developmental Services permission to contact the listed references and physician, and to conduct a criminal background check if appropriate. I understand that my ability to volunteer is dependent upon health and/or criminal background clearance as well as completion of CDS training and a personal interview.

Signature: _____ Date: _____

Parent signature (if applicant is a minor) _____



Developmental - Behavioral Pediatrics, Kidnetics, Pediatric Orthotics and Prosthetics, and The Wonder Center of The Children's Hospital of the Greenville Health System

Medical-Legal Partnership

Family Connection of SC

Thrive Upstate - Kidventures

Clarity: the Speech, Hearing and Learning Center

