Volunteer Application

Alzheimer's Resource of Alaska

Our Mission

To support Alaskans affected by Alzheimer's disease, related dementias and other disabilities to ensure quality of life.

Thank you for your interest in the Alzheimer's Disease Resource Agency of Alaska volunteer program. The secure information you provide on your application is for internal use only and for the sole purpose of matching applicants with suitable positions.

After reviewing your application, we will contact you to set up a mutually convenient time to meet to discuss your skills, interests and time availability and the various options available to find a satisfactory and rewarding position.

Applicant

Name: _____
First M.I. Last

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Day Phone: _____ Evening Phone: _____

Best time to call: _____

Date of birth: _____ Education: _____

Languages spoken: _____

Emergency Contact

Name: _____

Phone: _____

References

1. Name: _____
First M.I. Last
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

2. Name: _____
First M.I. Last
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

3. Name: _____
First M.I. Last
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Skills and Experience

- ☐ Art/Graphic Design
- ☐ Clerical
- ☐ Computer
- ☐ Counseling
- ☐ Education
- ☐ Event Planning
- ☐ Finance
- ☐ Health Care
- ☐ Interpretation
- ☐ Legal
- ☐ Photography
- ☐ Public Speaking
- ☐ Public Relations
- ☐ Spiritual Care
- ☐ Writing
- ☐ Other: _____

Possible Assignments

Please check the areas you are interested in.

- ☐ Advocacy
- ☐ Facility Maintenance
- ☐ Interpreter
- ☐ Photographer
- ☐ Fundraising events
- ☐ Health Fairs
- ☐ Office work

Hours you can commit to volunteering:

☐ Weekly: _____ ☐ Monthly: _____ ☐ Special Projects: _____ ☐ Other: _____

Volunteer Expectations

Why do you want to volunteer with the Alzheimer's Resource of Alaska?

What do you expect to gain from your experience working with us?

CONFIDENTIALITY POLICY

I, _____, serving as an employee, contractor, volunteer, and/or student intern for the Alzheimer's Disease Resource Agency of Alaska, Inc., have taken an oath of confidentiality and agree to the following:

In my position at the Alzheimer's Disease Resource Agency of Alaska, Inc., I promise to uphold the principle of ethics set forth by the Agency and never disclose information about a client, family, or donor without the written consent of the client, family or donor. This information includes the identity of the client, family or donor; content of conversations, content of professional opinions about the client, family or donor; or materials about the client, family or donor. If information needs to be exchanged with the Agency staff, it will be on a need-to-know basis and only include facts and never involve gossip or hearsay. At no time will I discuss a client, family or donor in public or private conversations.

The Health Insurance Portability and Accountability Act's (HIPPA) "Minimum Necessary" portion of the Privacy Notice supports the above statements.

_____	_____	_____
Signature of Volunteer	Printed Name of Volunteer	Date and Time

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Send to: 1750 Abbott Rd., Anchorage, AK 99507 or fax to: (907) 561-3315