



Senior Health Insurance Assistance Program (SHIP) & Senior Medicare Patrol (SMP) Volunteer Application

(Please type or print)

Name _____ Date _____

Address _____ City _____ State _____

Zip _____ Email _____ Cell Phone _____

Telephone (Home) _____ Telephone (Work) _____

Date of Birth: Month _____ Day _____ Year _____

Demographic Information:

Race ___ White ___ African American ___ Asian

___ American Indian/Alaskan ___ Hawaiian Pacific Islander ___ 2 or more races

Ethnicity

___ Hispanic ___ Non-Hispanic ___ Unknown

Emergency Contact Information:

Name: _____ Telephone _____

Relationship to Volunteer _____

Volunteer Interests/Availability: (Please designate first and second choice.)

___ Marketer ___ Administrative Assistance ___ Community Presentations/Outreach

___ Screener ___ Counselor ___ SMP Assistant

What days and times would you be available to volunteer? _____

Background/Interests:

What would you like to get out of your volunteer experience? _____

Please list your experience with Medicare/Health Insurance _____

Where did you hear about volunteering with the Bureau of Aging & Disabilities?

What level of education have you completed? _____

Languages Spoken _____

Employment Information: (please check one):

I am: Employed Retired Student

Current School / Occupation _____ Full time Part time

References:

Please list at least two people as personal references who are not related to you and have known you for at least one year

Name _____ Phone _____

Name _____ Phone _____

As a Carroll County volunteer, the lasting impression you make on those you serve reflects directly on all of us. Please be sure your words and deeds will help build our program and its reputation for quality.

I, _____ agree to perform the volunteer duties to which I am assigned to the best of my ability and in a professional manner.

I understand that as a volunteer, authorized by the SHIP Program Coordinator, I am afforded liability protection with respect to damages to third parties to the same extent as county employees, as long as I am acting within the scope of my duties as a volunteer. I understand that there are inherent dangers in any workplace activity or program. Carroll County assumes no liability for injury to myself or damage to my personal property unless caused by the negligence of the County. I hereby certify that the information provided above is true and complete to the best of my knowledge.

I/we hereby release and hold harmless Carroll County, Maryland, its officials, agents and employees from liability or obligation arising from, or in connection with my volunteer activities.

Signature: Volunteer Applicant

Date