

## **SENIOR FRIEND APPLICATION FORM**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

In case of emergency, whom may we contact?

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### **MENTORING INFORMATION**

Which mentoring program(s) are you interested in:

- School**            -Mentoring a child at his or her school.
- Community**      -Mentoring a child in the community setting.
- Literacy**          -Tutoring a student at his or her school.

Age preference: \_\_\_\_\_ What times/days can you meet with your mentee? \_\_\_\_\_

### **EMPLOYMENT**

Are you presently employed? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place: \_\_\_\_\_ Work hours and days: \_\_\_\_\_

Business phone: \_\_\_\_\_ May we contact you at work? \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

Previous work experience: (List any job sand employment history, or attach a resume):

### **VOLUNTEER EXPERIENCE**

Place	Type of Work	Dates	Supervisor
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Experience with children 6 to 16 years \_\_\_\_\_

**EDUCATION**

Level completed: \_\_\_\_\_ Major subject of study: \_\_\_\_\_

Are you presently a student? \_\_\_\_\_ Where? \_\_\_\_\_

Full time: \_\_\_\_\_ Part time: \_\_\_\_\_

**SPECIAL SKILLS AND TRAINING**

For example: Public speaking, laws, community organization, writing, recreation, hobbies, and education: \_\_\_\_\_

**COMMUNITY INVOLVEMENT**

Organizations you belong to and any leadership roles: \_\_\_\_\_

**REFERENCE INFORMATION**

*Please list five people (not related to you) that we may contact for references:*

	<b><u>NAME</u></b>	<b><u>ADDRESS</u></b>	<b><u>CITY &amp; STATE</u></b>	<b><u>PHONE #</u></b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

**I understand that my name will be added to the list of volunteers making a difference in our community. The list is maintained at Western Wellness Foundation and the Best Friends Mentoring Program.**

\_\_\_\_\_  
**APPLICANT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

**Please complete the attached Release of Information Authorization. Thank you.**

**How did you hear about mentoring opportunities through the Best Friends Mentoring Program?**

*(please check all that apply to you)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Radio                  | <input type="checkbox"/> Newspaper                    | <input type="checkbox"/> Guest speaker at work/school  |
| <input type="checkbox"/> TV                     | <input type="checkbox"/> Friend/Co-worker             | <input type="checkbox"/> Counselor/Social Worker, etc. |
| <input type="checkbox"/> Volunteer Center/ RSVP | <input type="checkbox"/> Other (please specify) _____ |  |

RELEASE OF INFORMATION AUTHORIZATION

Please Print Neatly

<b>NAME:</b>	
<b>DOB:</b>	
<b>SSN:</b>	
<b>DRIVER'S LICENSE #:</b>	<b>ISSUING STATE</b> _____
<b>PRESENT ADDRESS:</b>	

**Other places I have lived (city, county & state):** \_\_\_\_\_

**My former names (maiden name or other names):** \_\_\_\_\_

Western Wellness Foundation, Inc. is hereby authorized to conduct a law enforcement background investigation and a protective services investigation concerning myself and relating to the Best Friends Mentoring Program and any of its programs, events or activities.

I attest that the statements answered on this application are full and true to the best of my knowledge. Because I understand it will be necessary for Western Wellness Foundation, Inc. to investigate my background and to check my character references, I give my consent for this information exchange and authorize such agencies (including, but not limited to County Social Service office, Law Enforcement agencies and any person associated with these agencies) to release any information requested by Western Wellness Foundation, Inc.

I understand that information revealed in the background investigations may be released to Dickinson State University, Dickinson Public Schools, Dickinson Catholic Schools, or other entities with which the Program has a relationship. **I hereby release from liability and hold harmless all persons and corporations supplying this information to Western Wellness Foundation and its agents. A photocopy or facsimile (fax) of this authorization is as effective as the original.**

I hereby request a copy of the background investigation results: \_\_\_no \_\_\_yes

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Return to: **Western Wellness Foundation, Inc.**  
PO Box 542  
Dickinson, ND 58602-0542  
(701) 483-8615  
1-877-877-8685 (toll free)  
email: [friends@ndsupernet.com](mailto:friends@ndsupernet.com)

*Revised 10-19-2009*