NEW JERSEY CONFERENCE OF SDAs

VOLUNTEER STAFF APPLICATION FORM

Personal Information			Application Date: _____
Last Name		First Name	
Birthdate		Phone	
Address			
Email			
Marital Status		Name of Spouse	
Name/Age of Children			
Religious Affiliation		Home Church	
Do you now have, or have you had any injury/sickness that might limit your involvement in Children's/Youth Ministries activities? YES or NO If YES, Describe:			
Have you ever been accused, charged, or disciplined for any unlawful sexual conduct, child abuse, and/or child sexual abuse? YES or NO If YES, Describe:			

Work Experience That Would Qualify You to Work with Children / Youth:			
Job Title	Description of Duties	Date	Location

References who can verify you are suitable for work with Children / Youth:			
Pastor:	City:	State:	Phone:
Name:	City:	State:	Phone:
Name:	City:	State:	Phone:

Verified Volunteers		
Every adult age 18+ should complete the Verified Volunteers training & background check at http://www.ncsrisk.org/adventist/ and provide proof of completion.	Date Completed	

I have read and understand the Personal Vehicle Usage Recommendations (Please initial to the right)	
Note: Volunteer staff cannot begin work until their background and driving record checks have cleared. The above information is accurate to the best of my knowledge. I understand the information will be kept confidential in my club files.	
Signature: _____ Date: _____	

VOLUNTEER STAFF MEDICAL INFORMATION

Each staff member should complete the following form.
This confidential information is for club use only and will not be provided to the conference office.

Name:			
Health Information			
Food Allergies		**Medication Allergies**	
Physical Restrictions		**Medical Conditions**	
Preferred Local Hospital		**Physician (Name & Phone)**	
Insurance Company		**Insurance Policy Number**	
Diet Restrictions			
Current Medications	**Medication Name** **Dose Administered** **Time/Frequency Administered** **Reason for Administering**		
Health History	___ Asthma ___Hay Fever ___Sinus Trouble ___ Earache ___ Ear Tubes ___Fainting ___Tuberculosis ___Diarrhea ___ Bedwetting ___Kidney Disease ___Constipation ___Stomach Ache ___ Diabetes ___ Sleepwalking ___ Epilepsy ___ Rheumatic Fever ___ Heart Trouble ___ Glasses/Contacts ___ Menstrual Problems ___ Bee Sting Allergy ___ Poison Oak/Ivy Allergy ___ Other: _____		
Past Illness/Surgery Hospitalization/			
Immunizations	___ DTP Series ___Polio/OOPV ___ Measles ___German Measles/Rubella ___Tetanus ___Tuberculin Test ___ Mumps ___Chicken Pox ___ Other: _____		
Other Health Information?			

Emergency Contact 1			
Name		Phone 2	
Phone		Relationship	

Emergency Contact 2			
Name		Phone 2	
Phone		Relationship	