



CAP Services

Transforming People and Communities

Early Childhood Development

Volunteers Interns Student Teachers Application

Date Completed ____/____/____

Category (Check one) Former Head Start Parent Other Adult Youth (13-17)

Name _____ Male Female

Address _____

City _____ State _____ Zip Code _____

Home Phone() _____ Work Phone() _____ Ext _____

Message Phone() _____

Language(s) English Other: Specify _____

TB Screening Questionnaire Completed Yes Date _____

If a "Yes" was answered to any of the questionnaire questions, you will need to have a TB test completed and the test results submitted before you potentially begin volunteering.

Profession _____

Center Primarily Using Volunteer _____

Service Areas - check all areas of interest

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Classroom Education | <input type="checkbox"/> Field Trips | <input type="checkbox"/> Material Preparation | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Meeting Preparation | <input type="checkbox"/> Office Work | <input type="checkbox"/> Health Services | <input type="checkbox"/> Policy Council/Committee |
| <input type="checkbox"/> Recruitment | <input type="checkbox"/> Transportation | <input type="checkbox"/> Support to Other Families | <input type="checkbox"/> Grantee/Delegate Board |
| <input type="checkbox"/> Food Service | <input type="checkbox"/> Fund Raising | <input type="checkbox"/> Maintenance/Construction | <input type="checkbox"/> Other: Specify _____ |

Volunteer Availability

I have transportation to and from the work site? Yes No

I am available to work (note hours) Mon. _____
 Tues. _____
 Wed. _____
 Thurs. _____
 Fri. _____

To be completed by staff

Scheduled Work Time(s) _____

Start Date _____

Completion Date _____

Date "Background Check" Initiated _____

Head Start Contact (please print) _____