Oregon Senior Health Insurance Benefits Assistance Program Volunteer Application

Date: ____________________

Full name: ______________________________ Phone: ____________________

Address: ____

City: ________________________ State: ______________ ZIP: __________

E-mail address: ____________________________________

Employment History

Dates: from ____ to ____ Employer: ________________ Job title: __________

Type of business: ______________________ Supervisor: ________________

Job duties: ____

____

____

Dates: from ____ to ____ Employer: ________________ Job title: __________

Type of business: ______________________ Supervisor: ________________

Job duties: ____

____

____

Other employment: ____

____

Volunteer Work History

Date: from _____ to _____ Organization: ____________________________

Job title: _____________________ Type of organization: ______________

Supervisor: _________________________ Duties: ______________________

____

Date: from _____ to _____ Organization: ____________________________

Job title: _____________________ Type of organization: ______________

Supervisor: _________________________ Duties: ______________________

____

Other volunteer and community activities: ____________________________

____

____

Special skills, interests, and hobbies: ________________________________

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REFERENCES *(Non-relatives, please)*

	Name	Relationship	Day-time phone	Evening phone
1.				
2.				
3.				

VOLUNTEER COMMITMENTS *(Please read carefully)*

Will you be able to spend approximately three days within the next few months attending the SHIBA training course?............................ ❑ Yes ❑ No

Will you be able to attend bi-monthly meetings and trainings? .... ❑ Yes ❑ No

Do you have reliable transportation to visit homebound clients?................. ❑ Yes ❑ No

Are you willing to complete a record of assistance form for each client? ..... ❑ Yes ❑ No

How did you learn about the SHIBA program? ______________________

____

Why are you interested in joining the program? ______________________

____

Please describe any experience that you feel will help you as a SHIBA volunteer:

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____

____

Applicant's signature: ______________________ ***Date:*** __________

Call us if you have questions: (800) 722-4134.

Please return this completed form to:

SHIBA
250 Church St. SE, Suite 200
Salem, OR 97301-3921

For office use only:
Licensed agent? ❑ Yes ❑ No