



## Individual Volunteer Application

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone: \_\_\_\_\_ Driver/State ID: \_\_\_\_\_

Preferred pronouns (optional): \_\_\_\_\_ Can we add you to our substitution list?  Yes  No

**Do you consent for Cancer Care Of NCW to conduct a Washington State Patrol background check?**

Yes  No

Volunteer position(s) interested in: \_\_\_\_\_

Special skills/interests: \_\_\_\_\_

Are you fluent in any other languages? If yes, which? \_\_\_\_\_

Do you have any physical limitations? \_\_\_\_\_

Previous employment or volunteer experience:

References: Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Availability:

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

*Our House is open weekdays 9 am to 3 pm (we close by noon on Friday).*

*Virtual/at-home positions can be performed whenever is convenient for you.*

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Individual Volunteer Application - Extra Space Sheet

*Use this sheet to expand on any answers as needed or for comments/questions you have.  
You do not need to submit this sheet if unused. Thank you!*

Submit completed application packets to:

*Print & Mail-in*

Volunteer Application  
c/o Becky Elwell  
1708 Castlerock Ave  
Wenatchee, WA 98801

*E-mail*

becky@cancercarencw.com

*You should hear back from us within 3 business days*

We will e-mail you any necessary forms

# Cancer Care Of North Central Washington Volunteer Background Check Release

Pursuant to Child/Adult Abuse Information Act RCW 43.43.830 - 43.43.845

Applicant Name: \_\_\_\_\_

**\*Required\***

First

Middle

Last

Alias/Maiden Names: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Gender assigned at birth: \_\_\_\_\_ Race: \_\_\_\_\_

**\*Required\***

MM/DD/YY

*Secondary dissemination of this criminal history record information  
response is prohibited unless in compliance with statute.*

In accordance with the above referenced statute, Cancer Care Of NCW must request disclosure of the following:

- (a) Convicted of a crime;
- (b) Had findings made against him or her in any civil adjudicative proceeding
- (c) Has both a conviction and findings against him or her.

Please use the space below to disclose any information that would apply:

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I hereby authorize a background check through the Washington State Patrol to give Cancer Care Of North Central Washington (CCNCW) all information relative to such verification and hereby release CCNCW from any and all liability for any claim or damage resulting there from. I hereby acknowledge that I have been informed by CCNCW that they may seek to obtain an investigative report that will include personal information regarding me, including but not limited to, driving record, drug testing and criminal convictions or arrest records, in order to assist CCNCW in making certain approval decisions. CCNCW agrees to inform you if a decision has been influenced by information contained in an investigative report.

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

**\*Required\***

**Cancer Care Of North Central Washington**  
**Media Release Form**

I hereby grant Cancer Care Of North Central Washington (CCNCW) permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based productions, without payment or other consideration.

I understand and agree that all photos will become the property of CCNCW and will not be returned.

I hereby irrevocably authorize CCNCW to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge CCNCW from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENT(S) / GUARDIAN(S) AS EVIDENCED BY THEIR SIGNATURE(S) BELOW:

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Printed Name

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Signature

---

Date

If under 18, PARENT(S) / GUARDIAN(S) MUST SIGN:

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Parent and/ Legal Guardian Signature

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Parent and/ Legal Guardian Signature

**Cancer Care Of North Central Washington**  
**Liability Waiver**

The undersigned hereby releases Cancer Care of North Central Washington, Inc. from any and all liability and claims of loss or personal injury arising out of his/her participation as a volunteer at Our House.

_____	_____	_____
Printed Name	Signature	Date

If under 18, PARENT(S) / GUARDIAN(S) MUST SIGN:

_____	_____
Parent and/ Legal Guardian Signature	Parent and/ Legal Guardian Signature