SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY
MENTAL HEALTH SERVICES ACT VOLUNTEER PROGRAM
VOLUNTEER APPLICATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ City _____ Zip Code _____

Street Address _____ City _____ Zip Code _____

Phone _____ Cell/Message Phone _____

EDUCATION: (check all that apply) ☐ GED ☐ High School Diploma ☐ College ☐ Post Graduate

Educational Degrees and/or Certificates _____

WORK/VOLUNTEER EXPERIENCE: (Please describe your past and present work and/or volunteer experience.)

IN AN EMERGENCY, PLEASE NOTIFY:

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____

Primary Care Physician _____ Phone _____

Hospital Preference _____

HOW DID YOU HEAR ABOUT OUR PROGRAM?

What do you hope to gain as a Volunteer in the MHSA Volunteer Program?

Have you ever committed, been convicted of, pled guilty to, or pled nolo contendere to a felony or misdemeanor? (Note: We perform background checks; however, conviction of a crime is not necessarily grounds for disqualification.) ☐ No ☐ Yes

If yes, please explain:

PERSONAL REFERENCES:

Please list two references. (Do not use your physician(s).)

Name Relationship

Address

Phone Number

Name Relationship

Address

Phone Number

I hereby affirm that the information provided on this application is true and complete to the best of my knowledge and I agree to have any of the statements verified by Shasta County Health and Human Services Agency or its representatives. I understand that providing any false or misleading information or any omissions may disqualify me from further consideration as an Mental Health Services Act (MHSA) Volunteer and may result in my immediate removal from the MHSA Volunteer Program, even if discovered at a later date.

I authorize representatives of Shasta County Health and Human Services Agency to conduct a thorough investigation of my activities. I authorize all references provided in this application, whom the agency or its representatives may contact, to provide all information about me. Furthermore, I agree to cooperate in such investigation and release from all liability or responsibility of Shasta County Health and Human Services Agency, all persons and entities acting on its behalf, and all persons and entities requesting or supplying such information.

Signature of Applicant Date:

Please send completed application to Shasta County Health and Human Services Agency, 2640 Breslauer Way, Redding, California 96001, Attention: MHSA Volunteer Program. A representative of the MHSA Volunteer Program will contact you to schedule a meeting regarding your application.