



OFFICE OF THE RHODE ISLAND STATE LONG TERM CARE OMBUDSMAN
located in
ALLIANCE FOR BETTER LONG TERM CARE, INC.

Date of Application: ____/____/____

First Name: _____ Last Name _____ "Nick name" _____

Street Address: _____ City _____ State ____ Zip Code _____

Primary Phone: _____ Secondary Phone: _____

E-mail: _____ Preferred method of contact? _____

Are you currently employed? _____

Type of Volunteer Assignment Applied For:

() Long Term Care Ombudsman () Volunteer Receptionist () Other

How were you referred to the Alliance? _____

Have you ever volunteered with us before? (circle) Yes No

Days/Hours Available to Volunteer:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Date available to begin training: _____

Any recurring time off needed? (ex: Spring Break, Winter Holidays, Summer etc.) _____

Who should be contacted in case of an emergency? _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

Have you ever been convicted of a felony? (circle) Yes No

Have you ever been convicted of a misdemeanor involving dishonesty, criminal sexual conduct, assault or battery, or any criminal drug statute? (circle) Yes No If Yes, Please explain:

The Alliance for Better Long Term Care requires a criminal background check for all potential Volunteers & Employees.

Alliance for Better Long Term Care is an Equal Opportunity Employer. Employment with the Alliance for Better Long Term Care is governed on the basis of merit, competence and qualifications and will not be influenced in any manner by race, age, color, sex, religion, sexual orientation, veteran status, national origin, marital status, mental or physical disability or any other legally protected status.



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1. Are you now or have you been previously employed in the healthcare field? (circle) Yes No

If Yes, when, where and job title? _____

2. Do you or any member of your immediate family (spouse, children, siblings, parents, in-laws etc) work in or have any financial interest in a long term care facility or service agency? (circle) Yes No

If Yes, please explain _____

3. Is any member of your family currently residing in a long term care facility, receiving home care or hospice services? (circle) Yes No

If Yes, what facility or agency? _____

4. Why do you want to become a volunteer?

5. The Volunteer Ombudsman program requires a commitment of 3-4 visits to your assigned facility each month plus 1 in-service per month. Would you be able to commit to this? (circle) Yes No

6. Area of the state you would most like to volunteer _____

7. Are you fluent in any other language(s) besides English? (circle) Yes No

If Yes, please list _____

8. Any additional information you would like to share such as special skills, interests or educational background

If you have a professional resume, feel free to attach it to this application

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REFERENCES

Please list three non-family employment/professional references that we may contact. Do not include anyone who lives with you.

1. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

2. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

3. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

I UNDERSTAND THAT ACCEPTANCE INTO THE VOLUNTEER OMBUDSMAN 36 HOUR TRAINING PROGRAM DOES NOT GUARANTEE A POSITION AS A VOLUNTEER OMBUDSMAN. A CRIMINAL BACKGROUND CHECK MUST BE COMPLETED PRIOR TO TRAINING.

SIGNATURE: _____ DATE: _____

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