CARROLL COUNTY
MENTAL HEALTH ADVOCATES
THE MISSING LINK TO MENTAL HEALTH
306B Bradley Street Carrollton, Georgia 30117
Office: 770-830-2048 cmhadvocacy@gmail.com

VOLUNTEER APPLICATION FORM

Full Name: _____

Home Address: _____

City: _____County: _____ State: _____ Zip code: _____

Daytime Telephone Number: _____ Sex: _____

Evening Telephone Number: _____ Ethnic Origin: _____

Current Employer: _____

Address: _____ Telephone #: _____

Length of Employment: _____ Position/Occupation: _____
Have you ever worked for a Mental Health Service or Court System Yes: ____ No: ____
Have you ever worked for the Department of Family & Children Services? (Include service as a foster parent) Yes: ____ No: ____
List any volunteer experience and how long:
_____
_____
_____

Do you have a valid Georgia driver's license? Yes: ____ No: ____

Do you own or have access to a car? Yes: ____ No: ____

Have you ever been convicted of any violation of the law other than minor traffic violations?
Yes: ____ No: ____

Have you ever sought treatment for, or are you currently in treatment for, a mental health problem?
Yes: ____ No: ____

How did you hear about the CMHA program?
_____
_____

Why do you want to volunteer for CMHA?
_____

Personal Information:
Marital Status: Married? Yes: ____ No: ____ Children & Ages: _____
_____

Education or Other Training:

Name of School/Program	Degree	Dates Attended

_____

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References:

List two (2) personal references (only one family member) **AND** two (2) professional references (salaried or volunteer work). Please provide an email for your references.

Personal:

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number (H) _____ (W) _____
Email Address: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number (H) _____ (W) _____
Email Address: _____

Professional:

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number (H) _____ (W) _____
Email Address: _____

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number (H) _____ (W) _____
Email Address: _____

I UNDERSTAND THAT ALL INQUIRIES WILL BE MADE TO VERIFY ALL STATEMENTS MADE IN THIS APPLICATION, AND TO CONDUCT ANY OTHER INVESTIGATION DEEMED NECESSARY TO DETERMINE MY SUITABILITY TO ACT AS A CMHA VOLUNTEER. I UNDERSTAND THAT APPLICATION DOES NOT ASSURE MY ACCEPTANCE INTO THE PROGRAM. I WILL BE RESPONSIBLE FOR ASSURING THAT MY REFERENCES WILL RETURN THE REFERENCE REQUEST FORM TO THE CARROLL COUNTY PROBATE COURT. I HAVE CARFULLY CONSIDERED THE JOB DESCRIPTION AND TRAINING SCHEDULE AND, IF ACCEPTED, WILL OFFER MY SERVICES AS A COURT APPOINTED SPECIAL ADVOCATE.

Print Name: _____

Signature: _____ Date: _____