CARROLL COUNTY
MENTAL HEALTH ADVOCATES
THE MISSING LINK TO MENTAL HEALTH

118 S. White Street Carrollton, Georgia 30117 * 770-830-2048 * cmhadvocacy@gmail.com

VOLUNTEER APPLICATION FORM

Full Name: _____

Home Address: _____

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

Telephone Number: _____

Email Address: _____

Sex: _____ Race/Ethnic Origin: _____

Education or Other Training: Name of School/Program _____

Degree_____ Dates Attended_____

Current Employer Name: _____

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 previous/current 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? What would you like to do as a volunteer?

_____

_____

CARROLL COUNTY
MENTAL HEALTH ADVOCATES
THE MISSING LINK TO MENTAL HEALTH

References:

List two (2) personal references (only one family member) AND two (2) professional references (salaried or volunteer work).

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 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 Mental Health Advocates.

Print Name: _____

Signature: _____ Date: _____