cancer care
of North Central Washington

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 ☐ PM ☐	AM ☐ PM ☐	AM ☐ PM ☐	AM ☐ PM ☐	AM ☐

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:

_____

_____

_____

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:

Printed Name	Signature	Date

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

Parent and/ Legal Guardian Signature	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