

The Cleveland Clinic is an Equal Opportunity Employer, and as such prohibits discrimination due to race, religion, gender, age, national origin, and physical or mental handicaps. Completion of an application and attendance at orientation does not guarantee placement. Decisions concerning assignments are contingent upon a successful interview, security clearance and TB testing.

## KEEP MEMORY ALIVE

Supporting the Mission of the Cleveland Clinic Lou Ruvo Center for Brain Health



ALZHEIMER | HUNTINGTON | PARKINSON | ALS | MULTIPLE SCLEROSIS



# Cleveland Clinic

**Volunteer Application:** Please print and mail or fax to 260-9797. All signature lines need a signature, not printed or typed.

Name \_\_\_\_\_ Date of Application \_\_\_\_\_  
First Middle Initial Last

Mailing Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_ Preferred Contact \_\_\_\_\_

**Shirt Size:** Small Medium Large X-large XX-Large XXX-Large (Please circle one)

Goals for your volunteer experience at Cleveland Clinic Lou Ruvo Center for Brain Health (CCLRCBH) \_\_\_\_\_

### Availability

Date available to begin \_\_\_\_\_ Total hours per week \_\_\_\_\_

How long do you plan to volunteer at CCLRCBH \_\_\_\_\_ Months \_\_\_\_\_ Years

HOURS	MON	TUES	WED	THURS	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

### Limitations

Are there any reasonable accommodations we should consider? Yes No

If yes, describe: \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### Education

School Name	City/State	Last grade completed	Graduate?	Degree/Diploma

Do you have any special skills, interests, hobbies, or musical talent that you think might benefit our patient's and caregivers?

Are you bilingual? Language \_\_\_\_\_ Speak \_\_\_\_\_ Read \_\_\_\_\_ Write \_\_\_\_\_

Language \_\_\_\_\_ Speak \_\_\_\_\_ Read \_\_\_\_\_ Write \_\_\_\_\_

If called upon would you be willing to assist staff as an interpreter if needed? Yes No

### Employment and/or Volunteer Experience

Are you currently employed? Yes No if yes, employer name: \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

#### Please list any verified volunteer service you have done in the past

Organization	Organization
Address	Address
Dates: from to	Dates: from to
Assignment	Assignment
Supervisor	Supervisor
Phone	Phone

**Person(s) employed with CC or KMA with whom you are related:**

Name \_\_\_\_\_ Dept \_\_\_\_\_ Relationship \_\_\_\_\_  
(Volunteers will not be assigned to same area as related employee.)

**Areas of Interest**

Indicate all areas where you have a volunteer interest.

_____ Keep Alive Fundraising Events and Activities	_____ Community Events (Health Fairs, Alzheimer's Walk, etc)
_____ Volunteer Callers (patient appointment reminders)	_____ Docent (tours of building)
_____ Caregiver Support Activities (Outreach)	_____ Resource Library (caregiver library volunteer)
_____ Administrative Office Assistance	_____ PT/OT (assist patients & caregivers)
_____ Lobby (facilitate patient and guest)	_____ Fundraising events
_____ Clinic visits (room patients assist on phones, assist with faxing, scanning, etc.)	

Create a Volunteer Position to fit your skills and desires \_\_\_\_\_

**Applicant Statement**

I certify that the information provided in this application is complete and accurate to the best of my knowledge. I understand that if I am accepted as a volunteer, statements discovered to be incorrect or misleading will be cause for my immediate termination. Cleveland Clinic has permission to contact directly references I have listed or any other sources concerning my prior volunteer, professional or personal history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_



# Cleveland Clinic

## VOLUNTEER SERVICES PROFESSIONAL REFERENCE FORM

Name of Reference \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Reference e-mail address \_\_\_\_\_ Phone \_\_\_\_\_

Applicant \_\_\_\_\_

The above applicant has applied for a volunteer position with Cleveland Clinic Lou Ruvo Center for Brain Health. We would appreciate your cooperation in checking the appropriate spaces below as they pertain to your knowledge of this applicant. Return this form at your earliest convenience, as the applicant's file is not complete without verified references. Thank you for your anticipated cooperation.

Dee King, Director of Volunteer Services

[dking@keepmemoryalive.org](mailto:dking@keepmemoryalive.org)

Fax: 702-260-9797

Number of years you have known applicant \_\_\_\_\_

Relationship to applicant: (friend, relative, employer, etc.) \_\_\_\_\_

*Please indicate how you rate the applicant with regards to the following four character qualities:*

	POOR	FAIR	AVERAGE	ABOVE AVERAGE	OUTSTANDING
Reliability					
Confidentiality					
Commitment					
Integrity					
Creativity					

*Additional Comments*

\_\_\_\_\_  
Cleveland Clinic Lou Ruvo Center for Brain Health has my permission to contact directly references I have listed or any other sources concerning my prior volunteer, professional or personal history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Potential Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_

Reference Signature \_\_\_\_\_ Date \_\_\_\_\_



## VOLUNTEER SERVICES PERSONAL REFERENCE FORM

Name of Reference \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Reference e-mail address \_\_\_\_\_ Phone \_\_\_\_\_

Applicant \_\_\_\_\_

The above applicant has applied for a volunteer position with Keep Memory Alive on behalf of the Cleveland Clinic. We would appreciate your cooperation in checking the appropriate spaces below as they pertain to your knowledge of this applicant. Return this form at your earliest convenience, as the applicant's file is not complete without verified references. Thank you for your anticipated cooperation.

Dee King, Director of Volunteer Services

[dking@keepmemoryalive.org](mailto:dking@keepmemoryalive.org)

Fax: 702-260-9797

Number of years you have known applicant \_\_\_\_\_

Relationship to applicant: (friend, relative, employer, etc.) \_\_\_\_\_

*Please indicate how you rate the applicant with regards to the following four character qualities:*

	POOR	FAIR	AVERAGE	ABOVE AVERAGE	OUTSTANDING
Reliability					
Confidentiality					
Commitment					
Integrity					
Creativity					

*Additional Comments*

\_\_\_\_\_  
Cleveland Clinic has my permission to contact directly references I have listed or any other sources concerning my prior volunteer, professional or personal history, and I release all parties from any possible damages from disclosing such information with or without prior notice from me.

Potential Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_

Reference Signature \_\_\_\_\_ Date \_\_\_\_\_



### SECURITY CLEARANCE RELEASE FORM

I hereby authorize Cleveland Clinic or their representatives, to contact any law enforcement agency and/or other governmental agency who may aid Cleveland Clinic in determining suitability for employment. I release those individuals and/or organizations contacted from all liability whatsoever for issuing the requested information. I acknowledge that Cleveland Clinic will conduct required searches of the federal exclusionary lists to include the Office of Foreign Asset Control, General Services Administration and Health and Human Services.

**PLEASE READ CAREFULLY BEFORE SIGNING:** Have you ever been convicted of or pled guilty to any criminal offense (other than minor traffic offenses)? (A yes answer will not automatically disqualify you from consideration.) Yes ☐  
No ☐

If you answered yes, please explain: \_\_\_\_\_

I hereby provide the following information so that background checks may be initiated for verification. I am aware that final placement is contingent upon completion of processing, including security clearance.

Are you being considered for: FT/PT CC Employee ☐ PRN Employee ☐ Volunteer ☒ Student ☐

Print full name: \_\_\_\_\_

Other legal names: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Passport Number: \_\_\_\_\_ Visa Number: \_\_\_\_\_

Current Address: \_\_\_\_\_

Prior Address 1: \_\_\_\_\_

Prior Address 2: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Cleveland Clinic Nevada  
Return to Dee King /dking@keepmemoryalive.org

## Photograph, Film or Vocal Recording Release



*Note: I authorize this release based on the following conditions:*

- *These records become the property of Cleveland Clinic Foundation/Cleveland Clinic Health System or its representatives*
- *This release is given without promise of compensation*
- *This release is effective until terminated by a retraction in writing from the person granting this authorization*
- *The parent/legal guardian and the subject do release to Cleveland Clinic Foundation any right, title and/or interest of any kind they may have in the records produced*

---

### A. Release to photograph, film or record vocally

The Cleveland Clinic Foundation\Cleveland Clinic Health System ("CCF") is committed to educating the public and other healthcare providers.

I hereby grant to CCF the right and authority to photograph, film and/or record vocally:

---

**Please Print**

**Subject/Patient (or child's) name**

**Age**

I hereby authorize the use and disclosure of my name, voice, image or likeness, including still photo, film and/or videotape and audiotape. I understand I have the right to request cessation of recording or filming at any time.

I understand this Authorization is in effect until it is revoked in writing. It may be revoked at any time to the extent that use or disclosure has not already occurred prior to my request for revocation. In order to revoke the authorization, I agree that I must notify Nicole Wolf in writing at [wolfn@ccf.org](mailto:wolfn@ccf.org) or by telephone at 702-263-9797. CCF shall through reasonable efforts attempt to cancel already published works incorporating my Released Information; however, CCF cannot guarantee the cancellation of such published works in part due to the fact that revocation may be impractical or impossible due to the nature of internet based news media and downstream access to additional sites. I agree the photos or images specified above become the property of CCF or its representatives and I waive the right to inspect or approve such work.

I agree this Authorization is given without promise of compensation. I further agree to release to CCF any right, title and/or interest of any kind they may have in the information or images produced and any direct/indirect remuneration to CCF. I agree to release and forever discharge CCF, its agents, officers and employees from any and all claims including arising out of or in connection with the use of said information, including but not limited to any claims for invasion of privacy, right to publicity or defamation. By signing below, I authorize CCF to use or disclose any personal likeness information specified in this Authorization.

---

**Signed (subject/patient, parent or legal guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

---

**Print Name**

**Phone number**