GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF AGING AND COMMUNITY LIVING

SHIP Volunteer Application Form

Date of Application: _____

General Information

*Applicant Name:_____

*Address: _____

*City:_____*State:_____*Zip:_____

*Phone:_____

*Email:_____

*What is the best way to contact you?_____

Interest in the SHIP program

Past experience, and/or skills that make you a fit for this program: _____

_____

_____

Prior volunteer experience:

_____

_____

Please tell us what you would like to get out of this volunteer experience: _____

_____

_____

How did you hear about this volunteer opportunity?

_____

_____

General Information

Click on the highest level of education **completed**:

High School or Equivalent Some College College Graduate Graduate School

Do you speak any languages other than English? If yes, please list language(s):

_____

SHIP volunteers **cannot work for insurance companies, have an insurance license and/or sell insurance for at least one year prior to volunteering**. A person cannot potentially receive any financial gain from becoming a SHIP volunteer counselor.

*Are you currently working in the insurance industry? _____ Yes _____ No

*If no, have you in the past 12 months? _____ Yes _____ No

*If yes, what were your responsibilities? _____

_____

Do you require any special accommodations? If yes, please describe:

_____

_____

Employment/Volunteer History

Please tell us about your most recent/relevant work experience, including paid and volunteer positions.

Most Recent Employer: _____

Position: _____ Phone: _____

Dates of Employment: _____ to _____

Previous Employer: _____

Position: _____ Phone: _____

Dates of Employment: _____ to _____

Previous Employer: _____

Position: _____ Phone: _____

Dates of Employment: _____ to _____

Commitment Terms

SHIP Volunteer Program requires a minimum of 100 hours of volunteer service in a calendar year.

I agree □

Please click on your availability:

Day	9am-1pm*	1pm-5pm*
Monday	Morning	Afternoon
Tuesday	Morning	Afternoon
Wednesday	Morning	Afternoon
Thursday	Morning	Afternoon
Friday	Morning	Afternoon

*Hours are flexible upon request

References

Please provide complete information for professional references (not relatives) that have known you for a minimum of one year.

Reference 1:

Mr./Mrs./Ms.:_____

Phone Number:_____

Email address: _____

Reference 2:

Mr./Mrs./Ms.:_____

Phone Number:_____

Email address: _____

Insurance/Liability

I understand that as a volunteer I am afforded liability protection with respect to damages to third parties to the same extent as the District of Columbia employees, as long as I am acting within the scope of my duties as a volunteer. I understand that there are inherent dangers in any workplace activity or program. District of Columbia assumes no liability for injury to myself or damage to my personal property unless caused by the negligence of the District of Columbia.

I hereby release and hold harmless District of Columbia, its officials, agents and employees from liability or obligation arising from, or in connection with my volunteer activities.

I agree □

Authorization and Certification

I certify that the information I provided in this application is true, complete, and accurate to the best of my knowledge. I also authorize the SHIP program to contact the references named with regard to my application to become a SHIP Volunteer. I also authorize the persons referenced to provide information in connection with my application and release them from any liability in regard to it.

I agree □

Thank you for your interest in being a SHIP Volunteer.

Please complete and submit this form and your resume via:

1) Email: volunteer.dacl@dc.gov

   Please attach the completed form and resume as a PDF.

2) Mail to: State Health Insurance Assistance Program (SHIP)

   250 E Street SW, 6TH Floor

   Washington D.C., 20024

   Attn: Melishe Ivey, Volunteer Coordinator

3) Or Click the button below to submit electronically:

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