



STATE LONG-TERM CARE OMBUDSMAN PROGRAM (SLTCOP)
Volunteer Application

Name: _____ Email: _____

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
(Please circle preferred telephone number)

Are you age 21 or over? Yes _____ No _____

Education: High School _____ College _____ Graduate Degree _____ Tech Training _____

Field of Study: _____

Why do you want to become a volunteer for the State Long-Term Care Ombudsman Program (SLTCOP)?

Employment Experience: (Describe skills and duties – Include resume)

Have you had any experience with long-term care residents and/or older adults? Please describe.

What experience have you had with a nursing home or assisted living facility? In what capacity?

What languages do you speak? _____

Do you drive or have reliable transportation? Yes ___ No ___



Do you have any relatives or friends closely connected with, employed by, or currently living in a nursing home or assisted living facility? If yes, please explain.

Please provide the name and phone number of a person we should notify in the event of an emergency.

Name: _____ Relationship: _____
Address _____
City: _____ State: _____ Zip: _____
Phone Number(s): _____

Please list two non-family references we may contact, such as teachers, employers or community members:

Name: _____ Tel #: _____
Relationship to you: _____

Name: _____ Tel #: _____
Relationship to you: _____

This position requires working with vulnerable adults so we may need to do a criminal background check. Would you grant permission? Yes ___ No ___

SIGNATURE: _____ DATE: _____

Thank you for your interest in volunteering for the State Long-Term Care Ombudsman Program. Please send this form to the Volunteer Developer and she will forward it to the appropriate program.

Phyllis Meyerson, Volunteer Developer
13412 Green Hills Ct
Highland MD 20777

OR call Ombudsman Program at the Maryland Dept. of Aging 410-767-1100