



## **VOLUNTEERING**

Volunteers are the heart of the Douglas Center for Hope and Healing and work directly with grieving children and teens. Volunteers are paired with children in their peer support group. Volunteers go through a 25 hour training before they can become facilitators. Volunteers meet twice-monthly and meet one hour before the children and teens come to group, and meet for an hour after group. Volunteers experience the grieving process personally as they explore their own feelings about death and loss and ensure grieving children and teens an experience of a safe haven for trust and sharing.

We are always looking for volunteers for the following positions:

- Fund Raising
- Marketing
- Help getting In-Kind donations
- Facilitating groups
- Spanish speaking facilitators

If you are interested in becoming a volunteer with the Douglas Center for Hope and Healing please fill out the application below and send to the Douglas Center for Hope and Healing, 1677 Lucerne St., Ste B, Minden, NV 89410.



## Douglas Center for Hope and Healing Volunteer Facilitator Training Application

**Personal Information:**

Ms.      Mrs.      Mr.

Sex:    Male      Female

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Work Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_ NV Driver's License #: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Employment History:**

Current Occupation/Title: \_\_\_\_\_

Employer's Name, Address and Phone Number	Position Held	Date of Employment
Current		
Previous		
Previous		

**Educational Background:** (Selection of volunteers is not based on education/license)

Are you presently attending school?    Yes    No    If 'Yes' please complete information below:

Name of School: \_\_\_\_\_ Field of Study: \_\_\_\_\_

Anticipated graduation date: \_\_\_\_\_ Will you receive academic credit for your volunteer work? Yes    No

Please Check those that you've completed: provide year graduated and field of study for each.

High School/GED \_\_\_\_\_ Bachelor's Degree \_\_\_\_\_

Specialized Training \_\_\_\_\_ Master's Degree \_\_\_\_\_

Associated Degree \_\_\_\_\_ Doctorate \_\_\_\_\_

**Professional Licenses and/or Certifications:**

Type	State	Date	Number	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Emergency Information**

Person to notify in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_



**Additional Information:** (Feel free to write on back page if more space is required.)

Describe your experience working with children/teens (volunteer, professional, personal). \_\_\_\_\_

Please list specific skills, interests and personal background you believe will be helpful in this volunteer position. \_\_\_\_\_

Hobbies: \_\_\_\_\_

Languages you speak in addition to English: \_\_\_\_\_

If you have ever participated in a support group, please describe: \_\_\_\_\_

If you have ever facilitated a support group, please describe: \_\_\_\_\_

If you have ever been convicted of a misdemeanor or a felony please indicate date(s) and describe the charges.\* \_\_\_\_\_

\*(Conviction of a crime, or pleading guilty to a criminal charge, will not necessarily disqualify you from a volunteer position with the Douglas Center for Hope and Healing. Conviction will be considered with respect to time, relatedness to your work as a volunteer and other relevant factors.)

If you are currently under the care of a physician or psychiatrist, please describe: \_\_\_\_\_

**Personal References:** Please provide the name, complete address and phone number of a person in each of these categories who knows you well, has a definite knowledge of your abilities, personality and qualifications and whom we may contact for a reference.

Full Name	Mailing Address	Phone
Employer/Supervisor (Current or past)		
Co-worker (Current or past)		
Friend		
Relative		



**Bereavement History:** Please indicate significant losses that you have experienced.

Your Relationship to Deceased	Year of Death	Your Age at Loss	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Being a Volunteer Facilitator:** (Feel free to write on back page if more space is required).

Please tell why you are interested in working with grieving children.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you hope to gain personally as a result of attending this training?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your expectations of participation in the Douglas Center for Hope and Healing program?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything to prevent you from keeping your ten-month commitment? If yes, please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Availability and Areas of Interest:**

Below are the times and days groups meet. Please check your availability and preference. Groups meet every other week. Time include one-hour pre-meeting and on-hour post-meeting sessions for facilitators, and one & on-half hour session facilitating children, teens or adults. There are no meetings in July and August.

Wednesday 5:30-7:30PM  Thursday 5:30-7:30PM

With which participants would you feel most comfortable spending time?

Please indicate 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choices of groups you'd like to work with.

3-5 year olds  6-12 year olds  11-14 year olds  
 13-19 year olds  adults

I would feel comfortable working with participants who have experienced:

Please indicate 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choices.

loss by suicide  a homicide  
 loss due to serious illness  an accidental death  
 loss of a sibling  loss of a grandparent

**Please carefully read the following.** Please check each item if agreeable and sign below. If not agreeable, please write your comments under signature line.

I understand that I am required to attend 20 hours (4 sessions) of Volunteer Facilitator Training before I become a facilitator in a peer group sponsored by Douglas Center for Hope and Healing.

I understand that the Douglas Center for Hope and Healing reserves the right to accept or reject any potential trainee as a facilitator even after he/she has completed 20 hours of training.

I understand that this training is offered to those who intend to volunteer for at least 10 months as a facilitator of a peer support group sponsored by the Douglas Center for Hope and Healing and that the minimum commitment is for 3 ½ hours per session in a group that meets every other week.

I understand that if I am accepted as a facilitator, I will be asked to complete a 'Request for Nevada Criminal History Information' form and pay the fee required by the State of Nevada.

I declare the information provided by me in this application is true, correct and complete to the best of my knowledge. I authorize you to verify any and all information provided herein.

**\*\*Please not that volunteer facilitators are required to attend all hours of the training.\*\***

**\*\*Douglas Center for Hope and Healing reserves the right to accept or reject all potential volunteers.\*\***

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