VOLUNTEER DRIVER APPLICATION

Aging Services for Communities
212 First Street South, PO Box 7
Montgomery MN 56069
507-364-5663 Ext. 1
transportation@aging-services.org

NAME (LAST, FIRST, MIDDLE): ____

HOME ADDRESS: ____

CONTACT NUMBER: ____________________________ CELL NUMBER: ____

EMAIL ADDRESS: ____

DATE OF BIRTH: _______________________________ SOCIAL SECURITY NUMBER: ________________________________

DRIVER'S LICENSE NUMBER: __________________________________ EXPIRATION DATE: ___________________________

DRIVER'S LICENSE CLASS: ___________________

EMERGENCY CONTACT PERSON & PHONE NUMBER: ____

*VEHICLE DESCRIPTION (YEAR, MAKE, MODEL): ____

COLOR: ___________________________________ LICENSE PLATE NUMBER/LETTERS: ____________________________

*We will ask for proof and take a copy of your motor vehicle insurance card. We need your insurance face sheet with the type of insurance and the amounts for liability/comprehensive/collision (by MN law you only have to carry liability). ASC's excess automobile liability insurance becomes effective if you carry $50,000.

DO YOU HAVE EXPERIENCE DRIVING FOR OTHER PROGRAMS OR BUSINESSES? ____________________________________

WHAT DAYS OF THE WEEK ARE YOU ABLE TO DRIVE? ____

WHERE WOULD YOU BE WILLING/COMFORTABLE DRIVING? IN COUNTY ONLY _______ TO ROCHESTER _______

TO MINNEAPOLIS/ST PAUL _______ TO MANKATO _______ TO FARIBAULT _______ TO NORTHFIELD ________

I AM WILLING TO DRIVE ANYWHERE _______

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO
IF YES, EXPLAIN:
____

HAVE YOU HAD ANY ACCIDENTS IN THE LAST 12 MONTHS? YES NO If yes, please date and give a brief explanation:

____

**ARE YOU ON ANY SEIZURE MEDICATION? YES NO

ARE YOU ON MEDICATION THAT WOULD IMPAIR YOUR DRIVING ABILITY? YES NO

**If you are on anticonvulsive medication, you are not eligible to be a volunteer driver for ASC. If once you are volunteering and the doctor prescribes an anticonvulsive medication or you have a seizure, you are to notify ASC and remove yourself from being a volunteer driver.

PLEASE LIST 3 REFERENCES (DO NOT LIST FAMILY OR RELATIVES) INCLUDE THEIR NAME, ADDRESS, PHONE NUMBER, HOW LONG AND HOW YOU KNOW THEM:

1. ____

   ____

2. ____

   ____

3. ____

   ____

NO SMOKING POLICY

ASC HAS CHOSEN TO DEVELOP A "NO SMOKING" POLICY. THIS IS TO PROTECT BOTH THE ENVIRONMENT AND SAFETY OF OUR CLIENTS AND DRIVERS. PLEASE REFRAIN FROM SMOKING UNTIL OUT OF THE VEHICLE.

VEHICLE POLICY

1. VEHICLES SHOULD REMAIN CLEAN, CLEAR OF TRASH ON THE FLOOR AND SEATS.
2. WINDOWS MUST BE KEPT CLEAN. CLEAN WINDOWS PROVIDE A CLEAR VIEW FOR SAFETY REASONS.
3. ASHTRAYS SHOULD BE EMPTIED REGULARLY.
4. NO LITTERING OUT OF WINDOWS.

PROFANITY

PROFANITY, SWEARING, RACIAL COMMENTS WILL NOT BE MADE OR TOLERATED BY ASC.

MY SIGNATURE GUARANTEES THAT THE INFORMATION ABOVE IS TRUE, AND THAT I WILL USE MY PERSONAL AUTOMOBILE IN VOLUNTEER SERVICE. I WILL ARRANGE TO KEEP IN EFFECT MY AUTOMOBILE LIABILITY INSURANCE, NOTIFY ASC IF I HAVE A SEIZURE, DWI OR START TAKING ANTICONVULSIVE MEDICATION. LASTLY, I GIVE PERMISSION TO ASC TO CONDUCT A BACKGROUND CHECK. I WILL FOLLOW ALL THE POLICIES THAT ASC HAS STATED ABOVE.

SIGNATURE: ____ DATE: _________________________

Aging Services for Communities
Confidentially Statement

All individuals serving as Board Members, Employed Staff or any Volunteer position with ASC are to respect the confidentiality rights of those receiving care through this organization. No employee or volunteer is to disclose confidential information on any client they are providing service to.

Employees and/or Volunteers are no to discuss confidential information concerning any client in an area where one may be overheard (i.e. doctor office waiting rooms, hospital waiting rooms, courthouse waiting rooms, etc.). Employee and Volunteers are encouraged to use first names only when discussing situations involving their clients.

Confidential information on a client includes transportation request forms, assessments, referrals, and all information contained on it, any supplemental records used to update a client's services, and any other computer records maintained on a client. It also includes any information received verbally from the client and any information on the client's financial family, medical or social situations. Any documents and information relating to a client must be fully safeguarded and released only to authorized persons.

Emails and Transportation Request forms are to be guarded and kept confidential. Please delete and/or destroy information on a client when no longer needed. When transporting, keep information on other clients safeguarded and out of site.

Anyone breaking confidentiality on a client that they are transporting will be dismissed from this program immediately.

____ ________________________

(Print Name and Sign Please) (Date)

Revised 3/2023

Aging Services for Communities
Photo Release

This Photo Release "Release" is made effective on this ____ day of _____________, __________. I _________________________. Hereby grant and authorize AGING SERVICES FOR COMMUNITIES the right to edit, alter, copy and make use of all photos and or videos taken of me to be used in and/or for promotional materials without payment or consideration. This use includes but is not limited to publishing on the internet, emails, magazines, pamphlets and advertisement flyers in whatever manner ASC finds useful in a lawful purpose.

These photos will become the property of ASC and will not be returned.

Printed Name: ___________________________

Signature: ______________________________ Date: ____________________________