



**DENVER ADULT  
DOWN SYNDROME  
CLINIC**

700 Potomac Street, Suite A  
Aurora, CO 80011  
Fax: (303) 360-3713  
Telephone: (303) 762-6545  
director@denverdsclinic.org

## Volunteer Application

*Thank you for your interest in the Denver Adult Down Syndrome Volunteer Program. Please complete and return this form to the DADSC. Should you have any questions, please contact us.*

### Personal Information:

Today's Date \_\_\_\_\_ Your Birth Date/Age \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Email address \_\_\_\_\_

Your job title \_\_\_\_\_ Your Employer \_\_\_\_\_

If you are a student, your field of study \_\_\_\_\_

If you are a student, your school \_\_\_\_\_

Emergency contact name \_\_\_\_\_

Address \_\_\_\_\_

Phone(s) \_\_\_\_\_ Relationship to you \_\_\_\_\_

- What languages other than English do you speak?

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- Have you ever applied to be a Denver Adult Down Syndrome Clinic volunteer?

Yes     No

If yes, when, and for what program? \_\_\_\_\_

- How were you referred to the DADSC?

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### **Volunteer Interests:**

1. I am applying for:

Please check the volunteer opportunities that interest you:

Fundraising     *friend***DS**: Peer Mentor for Teen/ Young Adult Program

General office/clerical     Special Events     Buddy Walk     Other \_\_\_\_\_

2. Your availability for volunteer work (check all that apply)

Weekdays     Mornings     Afternoons     Evenings

Weekends     Mornings     Afternoons     Evenings

3. Describe your current or previous volunteer experience(s):

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4. Tell us why you are thinking about becoming a volunteer for DADSC:

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**Personal and Professional References:**

**Name:**

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**Phone(s):** \_\_\_\_\_ **Years Acquainted:** \_\_\_\_\_

**How do you know this person?**

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**Name:**

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**Phone(s):** \_\_\_\_\_ **Years Acquainted:** \_\_\_\_\_

**How do you know this person?**

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*If you are volunteering to work directly with children, teens or adults with Down syndrome, a release form for a criminal records inquiry will be sent to you.*

**Please mail in or fax completed form to:**

**The Denver Adult Down Syndrome Clinic  
700 Potomac Street, Suite A  
Aurora, CO 80011**

**Fax: (303) 360-3713  
Telephone: (303) 762-6545**

***Thank you for taking the time to complete this application.  
The DADSC Volunteer Coordinator will contact you soon.***