

General Volunteer Application

All information will be verified. If you will be in direct contact with APO clients, you may be asked to consent to Criminal History and Central Registry Background checks.

Aggieland Pregnancy Outreach, Inc.
2501 Texas Ave. S. # C-105
College Station, Texas
77840
979-764-6636
www.pregnancyoutreach.org
www.aggielandadoptions.org



DATE : ____/____/____

Name (printed) _____

Local **MAILING** Address _____ Apt # _____

City _____, Texas Zip _____

Cell Phone (_____) _____ Other Phone (_____) _____

Email _____

Local Church _____

Are you volunteering as part of a group? ____ If yes, group name _____

Please check one: Are you a student? ____ high school ____ college ____ no

How did you hear about AggieLand Pregnancy Outreach? _____

What interested you in volunteering with us?

In which of these areas are you interested in volunteering?

____ Childcare on Thursday evenings (____ Infants or ____ Toddlers) Experience level: Low/Med/High? _____

____ Process donations for the Mama Closet _____ Mentor Mom

____ Provide a Thursday evening meal (individually or as a group) _____ Support Team during Mama Club

____ Other _____ _____ Pit Crew (Friday clean-up team)

Do you have any previous experience, training, or certifications for working with young women and/or children (e.g., CPR, MSW, Child Safety)? If so, briefly describe.

May we have your permission to use photographs of you on our website and/or advertising? _____

APO's licensing regulations stipulate that our volunteers must not be on criminal probation, parole, or volunteering to work off community service hours for the courts. By signing below, you certify that you are not currently on criminal probation, parole, or working off community service hours for the courts.

Signature of applicant _____ /_____/_____

Tuberculosis Screening Questionnaire

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Name _____ Date of Birth _____
 Address _____ Apt# _____
 City _____ Zip Code _____
 Telephone _____ Alternate _____ Gender: Male Female

APO is required to screen for tuberculosis. The questionnaire below is designed to determine if you could be at risk for having TB. If it is determined that you are at risk, APO will require that you have a TB skin test and possibly a chest X-ray.

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING 'YES', 'NO', or 'DON'T KNOW.'

This information is confidential and will not be released.

Your History	YES	NO	DON'T KNOW
1. Have any immediate family or household members had contact with anyone diagnosed or treated for tuberculosis (TB) in the past 5 years?			
2. Do you inject illicit drugs?			
3. Are you a resident, employee, or health care worker who serves high risk clients? (nursing home, correctional facility, mental institution, homeless shelter)			
4. Have you spent more than 1 month outside the United States in the past 5 years? If yes: which country? _____			
5. Do you have any risk factors for a low immune status? (HIV, steroids, substance abuse, diabetes, cancer, kidney failure, leukemia)			
Your Medical History/Symptoms in the past 3 months	YES	NO	DON'T KNOW
1. Do you have a cough that has lasted longer than 3 weeks?			
2. Have you coughed up mucus or blood?			
3. Have you had fever, chills, or night sweats?			
4. Have you lost your appetite for food?			
5. Have you recently lost weight without dieting?			
6. Have you been feeling very tired?			
7. Have you ever had a positive TB skin test?			
8. Have you ever had an abnormal chest x-ray?			
9. Have you ever been told you had TB?			