CITY OF COMMERCE
MUNICIPAL VOLUNTEER APPLICATION

2535 Commerce Way
Commerce, CA 90040
(323) 722-4805
www.ci.commerce.ca.gov

Dept/Div_____

Date Assigned_____

Date Terminated_____

Volunteer Profile

Please complete this profile in as much detail as possible so that a volunteer assignment can be made to match your needs, abilities and schedule. You may be contacted if a volunteer assignment becomes available.

NAME_____ Student_____ Retired_____ Intern_____ Other_____
Please Print

ADDRESS_____ ☐ Male ☐ Female
Number Street

_____ E-mail_____
City Zip Code

Phone_____ _____
Home Message

Do you have a valid California Driver's License? Yes____ DL#_____ No___

Check the departments below in which you have an interest:

_____ City Administrator's Office
_____ City Clerk
_____ Finance
_____ Human Resources
_____ Information Technology
_____ Library Services
_____ Parks & Recreation
_____ Planning
_____ Public Information Office – Graphics/Cable TV
_____ Public Works & Development Services
_____ Public Safety & Community Services
_____ Transportation
_____ Other

IN CASE OF EMERGENCY:

1._____ PHONE #_____

2._____ PHONE #_____

PHYSICIAN OR HOSPITAL TO CALL IN EMERGENCY:

_____ PHONE #_____

PLEASE PRINT – This information will be detached from your profile card and used for research and statistical purposes only.

YOUR NAME: (Last) (First) (M.I.)		
ETHNIC BACKGOUND: Choose the one (ONLY ONE) ethnic group with which you most closely identify yourself. ☐ White ☐ Hispanic ☐ American Indian ☐ Other ☐ Black ☐ Asian ☐ Pacific Islander ☐ Alaskan Native	**SEX:** ☐ Female ☐ Male	**Age Group:** ☐ Under 40 ☐ Over 40
DISABLED: ☐ Yes ☐ No If there is any reasonable accommodation necessary, contact the Human Resources Department at 323-722-4805	How did you hear about the volunteer program (Circle One)? →	Radio / TV Station Newspaper Magazine Other Human Resources City Employee Job-Line Friend / Relative

Briefly list work experience or volunteer experience:_____

_____

List skills, hobbies or interests related to the volunteer work you desire:_____

_____

EDUCATION AND TRAINING

Name and location of colleges and other schools	Yrs. attended	Did you Graduate?	Degree Received	Major

List at least two (2) local references (employer, teacher, or neighbor):

1._____
Name Address City/State/Zip Phone

2._____
Name Address City/State/Zip Phone

3._____
Name Address City/State/Zip Phone

Indicate languages other than English, which you speak fluently:_____

_____

List below the times that you are available to volunteer:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Must be at least 14 years of age to volunteer.

Signature of Volunteer_____Date_____

Under 18 years of age must have Parent or Guardian Consent.

Parent or Guardian Signature_____Date_____

CITY OF COMMERCE
MUNICIPAL VOLUNTEER SERVICES

Volunteer Services Agreement

Please complete a separate form for each Volunteer.

The City of Commerce reserves the right to select and approve a volunteer and/or the volunteer assignment.

Department_____ Division_____

Address of Volunteer Assignment_____

Description of volunteer assignment (be as detailed as possible)_____

_____

_____

_____

_____

# of hours per week required by position_____ Length of assignment_____

Starting Date:_____

Please indicate the days and times volunteer will be needed:

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Start							
End							
Total							

The end or completion of the volunteer assignment will be determined by the City at its sole discretion.

Supervisor Signature:_____ Phone_____ Date_____

Volunteer Signature:_____Date_____

Department Head Signature:_____Date_____

ACCIDENT / INJURY
AUTHORIZATION FORM TO CONSENT TO THE
MEDICAL / SURGICAL TREATMENT OF A MINOR

Pursuant to California Family Code Sections 6902 and 6910, I the undersigned, parent and/or legal guardian of _____ whose date of birth is _____ do hereby authorize medical and/or surgical treatment by a State of California (hereinafter "State") licensed Medical Doctor (M.D.) and/or a State licensed hospital and/or a State licensed Hospital Emergency Room and/or a Private Practice Office operated by a State licensed Medical Doctor (M.D.), duly certified and licensed and/or their representatives as agent(s) for the undersigned to consent to any x-ray, laboratory, anesthetics, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of a licensed Medical Doctor (M.D.) per the provisions of the Medical Practice Act and who is on the staff of the accredited hospital, whether such diagnosis or treatment is rendered at the office of the treating physician or at an accredited hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority, consent and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his medical and surgical judgment may deem advisable.

In addition, you are authorized to release and/or to receive any and all medical records and/or related medical information pertaining to and/or aiding in the treatment rendered the Minor named above with regards to the Minor/Minor's Industrial Accident/Injury.

Dated:_____ Signed:_____
Parent or Legal Guardian

Dated:_____ Signed:_____
Witness Signature

In case of emergency, please notify:

Name:_____ Relationship:_____

Address:_____ City:_____ Zip:_____

Telephone:_____