



CONTINUING THE JAPANESE TRADITION OF CARE AND SUPPORT FOR SENIORS

VOLUNTEER INTEREST/AVAILABILITY FORM

LAST NAME: _____ FIRST NAME: _____ DATE: _____
ADDRESS: _____ CITY, STATE: _____ ZIP: _____
PHONE: (Day) _____ (Eve) _____ SEX: (circle) M F
E-MAIL ADDRESS: _____ DATE OF BIRTH: _____
OCCUPATION (LIST EMPLOYER OR SCHOOL): _____

WHAT DAYS CAN YOU VOLUNTEER? _____

WHAT TIMES CAN YOU VOLUNTEER? _____

WHICH PROGRAM(S) INTERESTS YOU THE MOST? _____

CLERICAL___ DAYCARE___ NUTRITION___ HOME DELIVERY___ RECEPTION___
ESCORT/HOME VISITOR___ SPECIAL EVENTS___ OTHER_____
LANGUAGE: PRIMARY_____ SECONDARY_____ OTHER_____

AREAS OF SPECIAL INTEREST/ABILITIES (i.e. Arts, Crafts, Exercise, Music): _____

PREVIOUS VOLUNTEER EXPERIENCE: _____

HOW DID YOU HEAR ABOUT KIMOCHI? _____

WOULD YOU LIKE TO BE ON KIMOCHI'S EMAIL/MAILING LIST TO RECEIVE UPDATES? YES NO

*****DO NOT FILL BELOW THIS LINE*****

Interview: _____ Orientation: _____ Starting Date: _____

Position: _____ Program: _____ Supervisor: _____

Comments: _____

CONTINUE TO OTHER SIDE

Kimochi Administration: 1715 Buchanan St., San Francisco, CA 94115 tel 415.931.2294 fax 415.931.2299
Kimochi Home: 1531 Sutter St., S.F., CA 94109 tel 415.922.9972 - Kimochi Nutrition: 1840 Sutter St., S.F., CA 94115 tel 415.931.2287
Kimochi Lounge: 1581 Webster St. # 202, S.F., CA 94115 tel 415.563.5626

IN CASE OF EMERGENCY, NOTIFY:

NAME: _____ RELATIONSHIP: _____ PHONE: _____
ADDRESS: _____ CITY, STATE: _____ ZIP: _____

GENERAL HEALTH (explain any medical or physical limitation that might impact your work as a volunteer):

LIST ANY ALLERGIES: _____

LIST ALL MEDICATION YOU ARE TAKING: _____

VOLUNTEER DECLARATION AND STATEMENT OF CONFIDENTIALITY

I certify that the above information is true and correct to the best of my knowledge. I agree to uphold the professional code of confidentiality. I understand that I am not to discuss any client information outside of the agency unless it is with an agency professional as part of the treatment plan or as part of privileged communication between myself and professional involved in the health and well being of the client.

SIGN HERE

YOUR SIGNATURE (REQUIRED BY ALL)

DATE

LIABILITY WAIVER

I, the undersigned, or as parent and guardian of _____ hereby waive and release Kimochi, Inc., its employees, agents, officers, personal representatives, successors or predecessors in interest, insurance companies from any and all actions, causes of action, claims, demands, costs, loss of services, expenses and compensation, on account of, or in any way growing out of, any and all known and unknown personal injuries, property damage and intangible damage resulting or to result from or by reason arising out of my work at Kimochi, Inc. and its facilities. I agree that if I am working as a volunteer, I am doing so at my own risk and I agree to hold Kimochi, Inc. and its employees and agents harmless for any harm that I may incur or while doing activities at Kimochi, Inc.

PRINT HERE

PARTICIPANT'S NAME (PLEASE PRINT)

SIGN HERE

PARTICIPANT'S SIGNATURE (REQUIRED BY ALL)

PRINT HERE

PARENT OR GUARDIAN'S NAME (PLEASE PRINT)

SIGN HERE

PARENT OR GUARDIAN'S SIGNATURE

DATE

PLEASE RETURN THIS FORM TO:VOLUNTEER PROGRAM
KIMOCHI, INC.
1715 BUCHANAN STREET
SAN FRANCISCO, CA 94115
FAX (415) 931-2299

*Thank you for your interest in our Volunteer Program. We will contact you upon review of your application.
Placement and scheduling are based on program needs.*