Self-Management Programs

(Chronic Disease, Chronic Pain, and Diabetes)

Volunteer Leader Application

Date: DOB (Month/Day/Year) / /

Name: Gender: Female Male Other Unknown

Street Address and Apt. No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell

Home

Office

Email Address:

 Check if Mailing Address is different from Home Address and enter Mailing Address below:

Street Address and Apt. No. or P.O Box: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What company/agency (if applicable) are you affiliated with?

Do you speak more than one language?

Yes

No If Yes, what other languages do you

speak?

Do you have transportation? Yes No

What is the highest level of education you have completed?

What is your volunteer experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Why are you interested in becoming a leader for the Taking Control of Your Health Chronic Disease Self-Management, Diabetes Self-Management, and/or Chronic Pain Self-Management Programs?­­­­­­­­­­­­­­­­­­­­­­­­­­

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I will volunteer in the following county(ies):

Collin Denton Ellis Erath Hood Hunt

Johnson Kaufman Navarro Palo Pinto Parker Rockwall

Somervell Wise

# Program of Interest (Please Check):

Benefits Counseling and Senior Medicare Patrol

Long Term Care Ombudsman

Taking Control of Your Health Programs Diabetes Self‐Management Chronic Disease Self‐Management

 Chronic Pain Self‐Management

 A Matter of Balance

# \*If you currently volunteer for one of the program(s) listed above, please list below, and name the organization(s) you volunteer for in that capacity:

**How did you hear about us? (***Please check***):**

AAA (which one?) Employer (please list the name)

o Do you receive paid time off or service credit for volunteering? Yes or No Faith Based Organization (please list the name) Friend or family referral (please list the name) Health fair (if so, which one)

Library (please list the name) Electronic Media (please check and list the name of the newspaper, radio, station, social media platform, etc.)

 Newspaper Radio Station

 Social Media Platform\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email

Senior Center/Community Center (please list name) Internet volunteer website i.e., Create the Good, Volunteer Match, etc. (please name website)

Other (please elaborate)

Thank you for volunteering to be a Self-Management Program Leader. Each leader must complete volunteer training to familiarize themselves with the techniques and curriculum of this highly effective, evidence-based program.

Each leader is eligible for certification through the North Central Texas Area Agency on Aging and Self-Management Resource Center after a full workshop series (6 sessions for on-site workshops and 7 sessions for online workshops) has been completed within 12 months of training. Thereafter, to remain certified as a leader, a full workshop series must be completed every 12 months.

I have read and understood the above.

Volunteer

Printed Name:

Signature:

Date: