STANDARD VOLUNTEER APPLICATION
THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION

Date: _____

Full Name: _____
Last First Middle Initial

SSN: _____/_____/_____ (Optional)

DOB: _____

Race: American Indian/Native Alaskan ☐ Asian ☐ Black ☐

Native Hawaiian or Pacific Islander ☐ Hispanic ☐ White ☐

Gender: Male ☐ Female ☐

Home Address:

_____
Street Apt#

_____
P. O. Box

_____
City State Zip

Phone: Home/Cell :(_____) _____ Work: (_____) _____

Email: _____

Occupation: _____

Business Address 1: _____

Business Address City: _____

Business Address State: _____ Business Address ZIP: _____

Business Address Phone: _____

Name of Employer: _____

Length of Time w/Employer: _____

Foreign Languages: Speak ☐ Write ☐

Have you ever been convicted of a felony? Yes ☐ No ☐

If Yes, what for? _____

Where? _____

Have you ever done volunteer work before? Yes ☐ No ☐

If Yes, where and how long? _____

Have you ever worked with incarcerated or civilly committed individuals before?
Yes ☐ No ☐

If Yes, where and how long? _____

When are you available to volunteer?

Availability	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Morning							
Afternoon							
Evening							

Do you have access to a car? Yes ☐ No ☐

If Owner of a car, Registration Number: _____

Driver License Number (SSN optional): _____

Does this volunteer job require any type of license or certification? Yes ☐ No ☐

How did you hear about this volunteer opportunity? _____

Briefly describe why you are interested in becoming a volunteer with the Department of Correction:

Are you visiting, have you visited, or are you corresponding with an incarcerated or civilly committed individual confined in any institution of MA Department of Corrections?
Yes ☐ No ☐

If yes, please explain/identify the incarcerated or civilly committed individual(s): _____

Please list any known family, friends, or associates who are currently confined to any institution of the MA Department of Corrections: _____

_____

_____

Have you ever been employed by the MA Department of Correction? Yes ☐ No ☐

If yes, please explain: _____

_____

_____

Do you have any life-saving medications (nitro pills, inhalers etc.) that you will need to keep on your person during your volunteer group? Yes ☐ No ☐

If yes, please provide a description of the Medication: _____

_____

References:

1. Name: _____ Phone: _____

   Address: _____

2. Name: _____ Phone: _____

   Address: _____

3. Name: _____ Phone: _____

   Address: _____

4. Name: _____ Phone: _____

   Address: _____

I hereby certify that information on this application is accurate to the best of my knowledge. I understand that all information on the application is subject to verification, and I consent to such verification as may be necessary in reference to my volunteer work.

Signed: _____ Date: _____

For office use only (do not write below this line):

Application Received: _____

Volunteer Coordinator: _____

Approved ☐ Denied ☐ Date: _____

Director of Treatment: _____

Approved ☐ Denied ☐ Date: _____ and/or

Deputy Superintendent: _____

Approved ☐ Denied ☐ Date: _____

APPEAL ONLY:

Superintendent: _____

Approved ☐ Denied ☐ Date: _____

Orientation Date: _____

Volunteer Assignment (Schedule): _____

_____

_____