



Long-Term Care Ombudsman Program
APPLICATION FOR VOLUNTEER OMBUDSMAN

Name _____ Date: _____

Address _____

City _____ Zip _____

Home (_____) _____ Work (_____) _____

E-Mail _____

1. Have you had any experience with an ombudsman or advocacy program?

Yes ____ No ____ If yes, please briefly describe: _____

2. Why would you like to be a Long-Term Care Ombudsman?

3. Have you ever visited a skilled nursing or board and care facility?

Yes ____ No ____ If yes, please describe the circumstances: _____

4. Describe any personal or professional experience that you have had with ill and/or older persons:

WISE *Healthy Aging*

5. What other volunteer assignments have you had?

6. Are you presently employed?

Yes ____ No ____ If yes, by whom and in what position? _____

7. What are your special interests, hobbies, or skills?

8. What is the highest level of education you have completed? Please check one of the following:

Elementary ____ High School ____ College ____ Degree ____

Field _____ Major _____

9. Do you speak any other languages besides English?

Yes ____ No ____ If yes, which languages do you speak? _____

10. Do you have transportation available for facility visits?

Yes ____ No ____

If yes, do you have auto and liability insurance? Yes ____ No ____

11. Do you foresee anything in your personal or business life that might prevent you from committing one year to the Ombudsman Program? Yes ____ No ____

If yes, please briefly explain: _____

12. How did you hear about the Long-Term Care Ombudsman Program?

13. Can you attend daytime training during the week? Yes ____ No ____



14. Can you commit to an average of 4 hours per week as a volunteer? Yes ___ No ___

15. Effective July 1, 2007, Senate Bill 1759 (Ashburn, Chapter 902, Statutes of 2006) requires existing and prospective volunteers to be fingerprinted and to undergo background clearances prior to certification as a Long Term Care Ombudsman.

Do you agree to participate in this process as part of certification? Yes ___ No ___

16. In case of emergency, please notify:

Name _____

Address _____

Home (_____) _____ Work (_____) _____

17. References:

Name _____

Address _____

Home (_____) _____ Work (_____) _____

Name _____

Address _____

Home (_____) _____ Work (_____) _____

Name _____

Address _____

Home (_____) _____ Work (_____) _____

Thank you for your interest in the Long Term Care Ombudsman Program!

**Please return to: WISE & Healthy Aging
Long-Term Care Ombudsman Program
1527 4th Street, 2nd Floor, Santa Monica, CA 90401
(800) 334-9473**