Washington State Long-Term Care
OMBUDSMAN PROGRAM

Southwest Washington Long-Term Care Ombudsman Volunteer Application

Today's Date:_____ Birthdate:_____

Name: _____

Address: _____

City, State and Zip Code:_____

Phone Number:_____

Work Experience:_____

_____

_____

_____

_____

Are you currently employed by a Long-Term Care Home? Circle one: Yes No

If yes, please specify home and year(s) of employment:

_____

_____

_____

_____

Have you had previous volunteer experience? Please name program/organization and specify your duties:

_____

_____

_____

_____

Special Skills or Interests: (i.e. Clerical, telephone, organizing, marketing, foreign languages, counseling, nursing, etc.)

_____

_____

_____

_____

Why do you want to become a volunteer ombudsman?

_____

_____

_____

_____

Are you willing to devote four hours per week to the Volunteer Ombudsman Program plus the time needed to follow through on critical issues? Circle one: Yes No

What is the best time of day to contact you?

_____

Please submit three professional references: (work, volunteering, home – please no family)

Reference Name: _____ Phone Number: _____

Reference Name: _____ Phone Number: _____

Reference Name: _____ Phone Number: _____

Long-Term Care Ombudsman Volunteer Application

Please save application as a pdf file and email the file to swwaltcop@dshs.wa.gov or print and mail it to: LTCOP, Area Agency on Aging & Disabilities of SW Washington, 201 NE 73rd Street, Vancouver, WA 98665. If you have any questions or concerns, please call us at 360-694-9007.