



# Volunteer Application Counselor

2421 Chicago Ave. S., Minneapolis, MN 55404 ■ P: 612-870-0565 ■ F: 612-870-4169

**Instructions:** Please complete this application and return it to Rita Sandidge, Volunteer Coordinator, at [rsandidge@walkin.org](mailto:rsandidge@walkin.org), by fax or by mail at the address listed above. **Please sign the acknowledgement on page five and the Statement of Applicant on page seven of this application.**

## CONTACT INFORMATION

Date of Application: \_\_\_\_\_ Available Start Date: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Type: Home  Cell  Work

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Current position is: Full-Time  Part-Time

Dates of current employment: \_\_\_\_\_

## PAST INVOLVEMENT WITH WALK-IN

1. Have you ever volunteered at Walk-In Counseling Center? Yes  No

If yes, in what role? \_\_\_\_\_ Dates: \_\_\_\_\_

## VOLUNTEER EXPECTATIONS & EXPERIENCE

1. How did you learn about Walk-In Counseling Center? \_\_\_\_\_

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**2. Why do you want to volunteer at Walk-In? What do you expect from this experience?**

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**3. Please check each shift that you are available, and indicate your 1<sup>st</sup> and 2<sup>nd</sup> preferences.**

Day	Shift Time	Frequency	Location	Preference
<input type="checkbox"/> Mon.	12:45p – 5:00p	(weekly)	Mpls: Walk-In	_____
<input type="checkbox"/> Mon.	4:45p – 8:30p	(bi-weekly)	St. Paul: Family Tree	_____
<input type="checkbox"/> Mon.	6:15p – 10:30p	(bi-weekly)	Mpls: Walk-In	_____
<input type="checkbox"/> Tues.	6:15p – 10:30p	(bi-weekly)	Mpls: Walk-In	_____
<input type="checkbox"/> Tues.	6:00p – 9:30p	(bi-weekly)	St. Paul: Neighborhood H.	_____
<input type="checkbox"/> Wed.	12:45p – 5:00p	(bi-weekly)	Mpls: Walk-In	_____
<input type="checkbox"/> Wed.	6:15p – 10:30p	(bi-weekly)	Mpls: Walk-In	_____
<input type="checkbox"/> Wed.	4:45p – 8:30p	(bi-weekly)	St. Paul: Family Tree	_____
<input type="checkbox"/> Thurs.	6:00p – 9:30p	(bi-weekly)	St. Paul: Neighborhood H.	_____
<input type="checkbox"/> Thurs.	6:15p – 10:30p	(bi-weekly)	Mpls: Walk-In	_____
<input type="checkbox"/> Fri.	12:45p – 5:00p	(bi-weekly)	Mpls: Walk-In	_____

**4. Please list your current and past volunteer experience.**

**Agency/Program:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

**Activities:** \_\_\_\_\_

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**Agency/Program:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

**Activities:** \_\_\_\_\_

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**Agency/Program:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

**Activities:** \_\_\_\_\_

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*Attach a separate sheet if necessary.*

**6. Please list any special areas of expertise or special skills (e.g. foreign language, sign language, sexual abuse counseling, chemical dependency counseling, etc.).** \_\_\_\_\_

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## CREREDENTIALS & TRAINING

1. Please list any degrees held and/or expected (student applicants please also complete the student addendum).

Institute: \_\_\_\_\_ Degree: \_\_\_\_\_

Major Field: \_\_\_\_\_ Year: \_\_\_\_\_

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Major Field: \_\_\_\_\_ Year: \_\_\_\_\_

Institute: \_\_\_\_\_ Degree: \_\_\_\_\_

Major Field: \_\_\_\_\_ Year: \_\_\_\_\_

2. Please list practica placements, internships, field experiences and any other supervised clinical experience. *Attach a separate sheet if necessary.*

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Client Population: \_\_\_\_\_  
Approx. Contact Hrs: \_\_\_\_\_

Treatment Modalities: \_\_\_\_\_  
\_\_\_\_\_

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Client Population: \_\_\_\_\_  
Approx. Contact Hrs: \_\_\_\_\_

Treatment Modalities: \_\_\_\_\_  
\_\_\_\_\_

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Client Population: \_\_\_\_\_  
Approx. Contact Hrs: \_\_\_\_\_

Treatment Modalities: \_\_\_\_\_  
\_\_\_\_\_

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Client Population: \_\_\_\_\_  
Approx. Contact Hrs: \_\_\_\_\_

Treatment Modalities: \_\_\_\_\_  
\_\_\_\_\_

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Client Population: \_\_\_\_\_  
Approx. Contact Hrs: \_\_\_\_\_

Treatment Modalities: \_\_\_\_\_  
\_\_\_\_\_

3. Have you ever been licensed\* or certified? Yes  No

If yes, please list current licenses and certifications in a mental health field:

License Held: \_\_\_\_\_ State: \_\_\_\_\_ Start Date: \_\_\_\_\_

License Held: \_\_\_\_\_ State: \_\_\_\_\_ Start Date: \_\_\_\_\_

License Held: \_\_\_\_\_ State: \_\_\_\_\_ Start Date: \_\_\_\_\_

*\*Walk-In Counseling Center does not provide clinical supervision for licensure and volunteers seeking licensure are expected to secure external supervision prior to volunteering.*

4. Please list any areas of competency or professional practice for which you are licensed or certified. \_\_\_\_\_

5. Has disciplinary action of any sort ever been taken against you by a licensing board, professional association, or an educational/training institution?

Yes  No

6. Are there any complaints pending against you before any of the above named bodies?

Yes  No

7. Have you ever had a civil or criminal suit brought against you relative to your professional work or is any such action pending?

Yes  No

*If you answered "yes" to any of the above three questions, please attach an explanation.*

### **STUDENT TRAINEE ADDENDUM**

Please provide the following information regarding your training institute and practicum/internship/field placement requirements.

Institute: \_\_\_\_\_

Program: \_\_\_\_\_

Degree: \_\_\_\_\_

Field Placement/Practicum Coordinator (Name, Phone, Email): \_\_\_\_\_

Number of hours required for practicum/internship/field placement:

Direct contact: \_\_\_\_\_ Total hours: \_\_\_\_\_

Anticipated duration of practicum/internship/field placement (months): \_\_\_\_\_

Anticipated start date: \_\_\_\_\_

## EMPLOYMENT EXPERIENCE

1. Have you ever been asked to resign or been terminated by a training program or employer? Yes  No  *If yes, please attach an explanation.*

**NOTE:** *In accordance with Minnesota State Law (Statute 148A, effective 8/1/86), Walk-In Counseling Center is obligated to make written inquiry to past employers in the mental health field over the past five years regarding possible sexual misconduct with clients.*

2. On the following page, list all **current and past** employment in the mental health field during the **past five years**. Include part-time, temporary, and fulltime positions, and all paid internships. Please list chronologically beginning with the most recent. Attach a separate sheet if necessary.

- OR -

Check here if you have **not** had any employment or paid internships in the mental health field in the past five years.

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

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

Title: \_\_\_\_\_

Description (setting, duties): \_\_\_\_\_

\_\_\_\_\_

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

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

Title: \_\_\_\_\_

Description (setting, duties): \_\_\_\_\_

\_\_\_\_\_

Agency: \_\_\_\_\_ Dates: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

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

Title: \_\_\_\_\_

Description (setting, duties): \_\_\_\_\_

\_\_\_\_\_

*Attach a separate sheet if necessary.*

I understand that my employer(s) will be contacted in accordance with MN Statute 148A.

\_\_\_\_\_  
**Signature of Applicant**

## REFERENCES

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Please provide contact information for three people who are familiar with or have supervised your clinical work within the last five years.

**Name:** \_\_\_\_\_

**Agency/Institution:** \_\_\_\_\_

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

**Name:** \_\_\_\_\_

**Agency/Institution:** \_\_\_\_\_

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

**Name:** \_\_\_\_\_

**Agency/Institution:** \_\_\_\_\_

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

## STATEMENT OF APPLICANT

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All information submitted by me in this application is true to the best of my knowledge. I understand that any significant misstatement in, or omission from, this application may be cause for denial of appointment as a volunteer or cause for dismissal from the volunteer staff.

By applying for appointment to the volunteer staff of Walk-In Counseling Center, I acknowledge that I have the responsibility to read the “Ethical Guidelines at Walk-In Counseling Center” and other Walk-In Counseling Center rules and regulations. I agree to act in accordance with these ethical guidelines and any other rules or regulations adopted by Walk-In. I also recognize I am bound and held to the ethical and professional standards associated with my professional degree and license in accordance with the state board responsible for my licensure.

I authorize the Walk-In Counseling Center, its staff, and representatives to consult with persons or institutions with which I have been associated and with others, including past and present employers, who may have information bearing on my professional competence, character, and ethical qualifications. I understand that a background check is conducted as part of the hiring process for this volunteer position and consent to that action. I release from liability all representatives of Walk-In for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I also release from any liability all individuals and organizations who provide information to Walk-In Counseling Center in good faith and without malice concerning my professional competence, ethics, character and other qualifications.

I understand and agree that I will notify Walk-In Counseling Center of any changes in my job or training status, licensure, censure or sanction by professional bodies, or any other information relating to my ability to perform as a volunteer at Walk-In.

\_\_\_\_\_  
**Applicant Name (please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Applicant**

