CONNECTICUT LIONS EYE RESEARCH FOUNDATION
LIONS EYE HEALTH PROGRAM

PEDIATRIC EYE SCREENING PROGRAM VOLUNTEER APPLICATION

A COPY OF A VALID GOVERNMENT ISSUED PHOTO IDENTIFICATION MUST BE ATTACHED TO COMPLETE THIS APPLICATION.

Name____Date_______________

Address____

City____State_____________Zip______________

Home Phone___________________________Business Phone_____________________________

Cell Phone_________________________________E-Mail________________________________

Date of Birth___________________________Occupation________________________________

Social Security # (Optional, mandatory if requested_____________________________________

Employer____

Address____

Lions Club affiliation____District_______________

Special certification (CPR, Medical, Etc.)____

Have you ever been convicted or plead guilty to any crime(s)? Yes____ No____

If yes, describe each in full ____

____

Have you ever been refused participation in any other youth related program? Yes____ No____

If yes, explain:____

____

Please list 3 references, at least one of which is not a member of your Lions Club:

Name____Phone________________________

Name____Phone________________________

Name____Phone________________________

As a condition of volunteering for the LEHP Pediatric Eye Screening Program, I give permission for LEHP to conduct a background check on me, which may include a review of sex offender registries, child abuse and criminal history records. I understand that my participation in this program is conditional upon LEHP receiving no inappropriate information on my background. I hereby release and hold harmless from liability CLERF, LEHP, its officers, volunteers, employees, or any other person or organization that may provide such information.

Applicant Signature____Date____________________