



GEORGIA VOLUNTEER HEALTH CARE PROGRAM VOLUNTEER PERSONAL REFERENCE QUESTIONNAIRE

Name of Volunteer Applicant

Date Completed

The Georgia Department of Community Health, Georgia Volunteer Health Care Program, requires that reference checks be completed for the above applicant. This applicant wishes to provide volunteer services to clients of the Georgia Department of Community Health that is associated with Hands of Hope Clinic. Your name has been given as a personal reference, and we would appreciate your comments on the following questions:

1. How long have you known the volunteer applicant? _____
2. To your knowledge, has the applicant ever been convicted of a crime? _____
3. Do you consider him/her to be of good moral character? If no, please explain. _____

4. Do you know of any reason why the applicant should not be trusted with or around children or persons with disabilities? _____ If yes, please explain: _____

5. Would you consider placing the responsibility of a child or a person with disabilities who is related to you with the applicant? _____
6. Do you have any additional comments concerning the applicant's character or reliability? _____

7. What is your relationship to the applicant? _____

Reference Signature

Name (please print)

Address

City/State Zip

Telephone

Thank you for your time.

Upon completion, please return this form to:

Carla Catalon-Scott
Georgia Volunteer Health Care Program
8075 Mall Parkway
Suite 101, Box 413
Lithonia, GA 30038