Four County Local Outreach to Survivors of Suicide (LOSS)

1st Responder Volunteer Application

Name_____

Street_____ City_____ Zip_____

Cell phone_____ Home phone_____

Email_____

What prompted you to volunteer for the LOSS team?

_____

_____

_____

Check any of the following that may qualify you as a 1st Responder?

☐ Survivor after Suicide (You have experienced the loss of a loved one to suicide)

Relationship_____ How long ago?_____

☐ Health Professional: What type?_____

☐ Minister/Clergy

☐ Other Experience_____

The volunteer commitment requires a significant investment of your time and energy. Volunteers will be put on a volunteer list and when a suicide occurs, volunteers will be called to asked if they are available at that time to respond. Debriefing will also be asked of our volunteers following the initial visit. Regular meetings will be held for the team volunteers to learn more about grief and to get to know other team members. What activities/ commitments are in your daily life (I.E. work 2nd shift) ?

_____

_____

What coping skills do you use handle stressful situations? What family/friend support do you have?

_____

_____

_____

(Turn over for second page)

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Please provide us with two references: one having to do with your employment, volunteer work or academic history; and one from someone who knows you well, personally (but not a relative). Let us know the preferred way to contact them. Please let your references know that we will be contacting them.

Name_____ Email_____

Phone_____ Best time to call_____

Street_____ City_____ Zip_____

Relationship_____

Name_____ Email_____

Phone_____ Best time to call_____

Street_____ City_____ Zip_____

Relationship_____

Please sign below authorizing Four County LOSS to contact your references and collect information about you.

Signature_____ Date_____

Please send this application to:

Pamela Pflum

Four County ADAMhs Board

T761 St. Rt. 66, Archbold, Ohio 43502

pam@fourcountyadamhs.com