

## Local Outreach to Suicide Survivors (LOSS) 1st Responder Volunteer Application

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Street \_\_\_\_\_

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

Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Home phone \_\_\_\_\_ E-Mail \_\_\_\_\_

What prompted you to be a volunteer for the L.O.S.S. team?

\_\_\_\_\_

\_\_\_\_\_

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

Survivor of Suicide (Affected by loss of a loved one to suicide)

Relationship \_\_\_\_\_ Month /Year \_\_\_\_\_

Mental Health Professional

Clergy / Faith Based Support

Other Experience \_\_\_\_\_

**The volunteer commitment requires a significant investment of your time and energy.** The training is a one-day 4-hour course. On-call availability to respond to a scene and complete debriefings are required. A minimum one-year commitment is required, and quarterly meetings will take place. For these reasons, please circle your general availability.

|                    |                    |                     |                    |                      |                    |                    |
|--------------------|--------------------|---------------------|--------------------|----------------------|--------------------|--------------------|
| Sun.<br>Mornings   | Mon.<br>Mornings   | Tues.<br>Mornings   | Wed.<br>Mornings   | Thurs.<br>Mornings   | Fri.<br>Mornings   | Sat.<br>Mornings   |
| Sun.<br>Afternoons | Mon.<br>Afternoons | Tues.<br>Afternoons | Wed.<br>Afternoons | Thurs.<br>Afternoons | Fri.<br>Afternoons | Sat.<br>Afternoons |
| Sun. Evenings      | Mon. Evenings      | Tues. Evenings      | Wed. Evenings      | Thurs. Evenings      | Fri. Evenings      | Sat. Evenings      |

What coping skills do you use to relax or handle stressful situations?

\_\_\_\_\_

\_\_\_\_\_

**REFERENCES**

L.O.S.S. follows rules and regulations governing fair employment/volunteer practices. As a volunteer applicant, your right to privacy shall be respected. The results of inquiries made in connection with your application for volunteering shall be treated in confidence by the organization.

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.

Name \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone \_\_\_\_\_ Best time to call \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship \_\_\_\_\_

Name \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone \_\_\_\_\_ Best time to call \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship \_\_\_\_\_

We will contact your references after your interview, so please let them know they may be receiving an e-mail, call or letter from us. Please read the following authorization carefully before signing.

I authorize the references listed above to give L.O.S.S. any and all information concerning my acquaintance with this reference, personal or otherwise. I release all parties from all liability for any damage that may result from furnishing or receiving this information.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Please send this application to:

Mental Health America of Licking County  
c/o Ms. Justina Wade  
65 Messimer Drive  
Unit 3  
Newark, OH 43055