



**Central Arkansas Trauma Recovery Network
Volunteer Information Form**

Name:		Date:	
Mailing Address:		City:	Zip:
Phone#1:		Phone#2:	
Email:		Fax#:	
For Therapist/Clinical Volunteer Position ONLY			
License Type & #:		Exp. Date:	
Malpractice Carrier:		Exp. Date:	
HAP Volunteer (please circle one):		Populations with whom you work:	
Yes No			
Are you RTEP/GTEP trained?		What is your comfort level now with early EMDR interventions (within a week or month of the incident)?	
Yes No			
Languages you speak:			
Are you interested in onsite crisis work? Yes No, ^{but I'm willing to work behind the scenes}			
Modalities in which you are trained, including crisis training:			
Other disaster response organizations with which you work:			
What other commitments do you have that could interfere with your TRN volunteer work?			
VOLUNTEER INTERESTS:			
Administration Tasks		Clinician for group work or Individual pro bonos	Emotional Support Team
Funding Committee		Grant Writing	Marketing & Advertising
Onsite Coordinator		Professional Development/ Training	Public Relations
TRN Secretary		Website Work	
Other:			
Previous experience that will be beneficial in your volunteer work with the TRN:			
What training would you like for yourself?			
Are you willing to have a background check? Yes No			
Administrative Notes:			

Signature _____

Date _____