FOR OFFICE USE ONLY
Date Received:_______________
By:_________________________

PEER VISITOR APPLICATION

APPLICANT INFORMATION

First name	Last name	Phone no. ( )

Mailing address	Email address

City	State	ZIP Code
What is your disability?	**Age**	**Gender** ☐ **Male** ☐ **Female**

How many years have you had a disability?	What language(s) do you speak?

MEMBERSHIP INFORMATION

How long have you been a PossAbilities member?

☐ Less than 1 year ☐ 1-2 years ☐ 2-5 years ☐ 5 years +

Please check one to identify your involvement with the program:

☐ 0 No involvement.
☐ 1 Minimal Involvement (once-a-year)
☐ 2 Some Involvement (2-3 events a year)
☐ 3 Consistent Involvement (frequent participation, volunteerism, and interaction with members)
☐ 4 Very involved (Routine and consistent, weekly participation, volunteerism, and interaction with members)

PEER VISITING EXPERIENCE?

Please check one:

☐ This is my first experience with peer visiting. ☐ I have been a peer visitor in the past.

AVAILABILITY

Please chose the days and times you are available.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ Weekends
☐ Evenings ☐ Daytime

WHY DO YOU WANT TO BE A PEER VISITOR? (Please explain in 50 words or less.)

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WHAT IS YOUR STORY?

The main purpose in visiting patients is to provide them with hope and encouragement. If you were to share your life's journey related to your disability what would your story be? (Please use 250 words or less.)

HOW DO YOU GIVE ENCOURAGEMENT?

What words of encouragement would you give a patient during a peer visit?

PROVIDE 2 CHARACTER REFERENCES.

These are people that you have known more than

First name	**Last name**	**Phone no.** ( )
Mailing address	**Email address**	
City	**State**	**ZIP Code**
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LOMA LINDA UNIVERSITY HEALTH

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WAIVER AND AGREEMENT

I, ___________________________ , the undersigned, agree that by submission of this application, I agree to hold Loma Linda University Health, and its trustees, officers, employees, volunteers and agents harmless from any and all claims, actions and/or cause of action arising directly or indirectly as a result of the decision made by PossAbilities. My signature verifies membership in PossAbilities and gives you permission to use my bio and related photos of me or my dependents in support of Loma Linda University Health or any of its divisions. I attest that the information provided in this application is true, correct, and complete to the best of my ability.

____   __________________

If under 18 years old - Parent or Guardian   **Date**

____   __________________

Signature of Applicant   **Date**