SMRC Leader Application
Taking Control of Your Health

Date:_______________ DOB (Month/Day/Year)________/_______/ ________

Name:___________________________________Gender: ☐ Female ☐Male ☐Other ☐ Unknown

Street Address and Apt. No: ____

City, State, Zip Code: ___________________________________ County: ________________

Phone: _________________________________ ☐ Cell ☐ Home ☐ Office

Email Address: ____

☐ Check if Mailing Address is different from Home Address and enter Mailing Address below:

Street Address and Apt. No. or P.O Box: ____

City, State, Zip Code: _________________________________ County: ___________________

What company/agency (if applicable) are you affiliated with? _____________________________

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Do you speak more than one language? ☐ Yes ☐ No If Yes, what other languages do you speak? ____

Do you have transportation? ☐ Yes ☐ No

What is the highest level of education you have completed? _____________________________

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What is your volunteer experience?

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Why are you interested in becoming a leader for the Taking Control of Your Health Chronic Disease Self-Management, Diabetes Self-Management, and/or Chronic Pain Self-Management Programs?

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☐ I will volunteer in the following county(ies):

☐ Collin	☐ Denton	☐ Ellis	☐ Erath	☐ Hood	☐ Hunt
☐ Johnson	☐ Kaufman	☐ Navarro	☐ Palo Pinto	☐ Parker	☐ Rockwall
☐ Somervell	☐ Wise				

Program of Interest (Please Check):

- ☐ Benefits Counseling and Senior Medicare Patrol
- ☐ Long Term Care Ombudsman
- ☐ Taking Control of Your Health Programs
  - ☐ Diabetes Self-Management
  - ☐ Chronic Disease Self-Management
  - ☐ Chronic Pain Self-Management
  - ☐ A Matter of Balance

***If you currently volunteer for one of the program(s) listed above, please list below and name the organization(s) you volunteer for in that capacity:** ______________________________________

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How did you hear about us? (*Please check*):

☐ AAA (which one?) ______________________________

☐ Employer (please list the name) ______________________________

- Do you receive paid time off or service credit for volunteering? ☐ Yes or ☐ No

☐ Faith Based Organization (please list the name) ______________________________

☐ Friend or family referral (please list the name) ______________________________

☐ Health fair (if so, which one) ______________________________

☐ Library (please list the name) ______________________________

☐ Electronic Media (please check and list the name of the newspaper, radio, station, social media platform, etc.)

☐ Newspaper______________________ ☐ Radio Station ______________________

☐ Social Media Platform______________________ ☐ Email

☐ Senior Center/Community Center (please list name) ______________________________

☐ Internet volunteer website i.e., Create the Good, Volunteer Match, etc. (please name website)

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☐ Other (please elaborate

Thank you for volunteering to be a Taking Control of Your Health Leader. Each leader must complete volunteer training to familiarize themselves with the techniques and curriculum of this highly effective, evidence-based program.

Each leader is eligible for certification through the North Central Texas Area Agency on Aging and Self-Management Resource Center after a full workshop series of 6 sessions for on-site workshops and 7 sessions for online workshops has been completed within 12 months of training. Thereafter, to remain certified as a leader, a full workshop series must be completed every 12 months.

☐ I have read and understood the above.

Volunteer

Printed Name: ____

Signature: ____

Date: ______________________________