

**CLINTON COUNSELING CENTER
MACOMB COUNTY JAIL SUBSTANCE ABUSE PROGRAM
AA & NA VOLUNTEER APPLICATION**

LAST NAME FIRST NAME FULL MIDDLE NAME

WILL YOU VOLUNTEER FOR AA or NA? _____

STREET ADDRESS CITY STATE ZIP CODE

AREA CODE & PHONE NUMBER OPERATOR LICENSE NUMBER

SEX RACE HEIGHT WEIGHT MARKS

EYES HAIR DATE OF BIRTH SOCIAL SECURITY #

IN CASE OF EMERGENCY CALL:

NAME: _____ PHONE: _____

IN CASE OF SICKNESS OR INJURY MY HOSPITAL IS:

MY DOCTOR'S NAME: _____ DOCTOR'S PHONE #: _____

I AM ALLERGIC TO:

I HAVE 1 YEAR OF ABSTINENCE & 2 YEARS FREE FROM LEGAL OBLIGATIONS. I AM AVAILABLE TO VOLUNTEER ONCE A MONTH FOR THE NEXT SIX MONTHS IN THE EVENING. I HAVE RELIABLE TRANSPORTATION TO GET TO AND FROM THE MACOMB COUNTY JAIL FOR VOLUNTEERING. ALL OF THE ABOVE INFORMATION IS ACCURATE AND COMPLETE.

SIGNATURE: _____

YOU WILL BE CONTACTED REGARDING YOUR ELIGIBILITY TO VOLUNTEER. IF ELIGIBLE, YOU WILL BE INVITED TO ATTEND A VOLUNTEER ORIENTATION.

REFERRED BY: _____

Send in to:
Macomb County Jail
43565 Elizabeth Rd.
Mt. Clemens, MI 48043
Att: Sue DeMara, Substance Abuse Program