Volunteer Service Application

We are an Equal Opportunity Agency. We consider applicants for all volunteer positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, the presence of a non-job related medical condition or handicap, or any other legally protected status. However, for the safety of our volunteers, the individuals we serve and our staff, there may be positions with a minimum age requirement.

(Please Print Clearly)  
Date of Application: _____________________________

Last Name: ___________________________  First Name: ___________________________  Middle: __________
Street Address: _____________________________  City: ___________________________  State: _______  Zip Code: __________
Telephone - Home: ___________________________  Cell: ___________________________  E-Mail: ___________________________

On what date would you be able to start your volunteer experience? _______________________________________
Which days and hours are you available to provide volunteer services? ________________________________

Area(s) of Interest:

☐ Clerical Work  ☐ Special Events  ☐ Infant/Daycare  ☐ Early Childhood
☐ School-age  ☐ Adult Division  ☐ Sports/Recreation  ☐ Horseback Riding
☐ Other ___________________________

Location(s) preferred:

☐ Barneveld  ☐ Boonville  ☐ Herkimer  ☐ Little Falls  ☐ Marcy  ☐ Chadwicks
☐ Poland  ☐ Rome  ☐ Sauquoit  ☐ Stittville  ☐ Utica  ☐ Special Events

How did you learn about us?

☐ I am an Employee  ☐ From an Employee  ☐ Advertisement
☐ Friend or relative  ☐ Other ___________________________

Have you ever been employed with us before?  ☐ Yes  ☐ No  Dates of employment: ____________________

Indicate any languages other than English in which you are fluent in spoken, written or signed form:

Spoken: ___________________________  Written: ___________________________  Signed: ___________________________

Education

School Name  Location (City, State)  Circle highest year completed

________________________________________  ___________________________  9  10  11  12

(High School)

________________________________________  ___________________________  1  2  3  4  Graduate

(College)  (Major)

________________________________________  ___________________________  1  2  3  4  Graduate

(College)  (Major)

(Continued on reverse)  Rev. 2/29/12
Applicant’s Statement

To the best of my knowledge, the information provided in this application for a volunteer experience is true, correct and complete. I authorize investigation of all statements contained in this application as may be necessary in arriving at a decision for a volunteer position, and understand that information provided in this application may be used to conduct a background check. The agency reserves the right to dismiss a volunteer who has provided incorrect information. Therefore, I understand that any false or misleading information given in my application or interview(s) may result in discharge. If accepted into a volunteer position, I agree to abide by the UPSTATE CEREBRAL PALSY policies, rules and regulations. I understand that acceptance of an offer of a volunteer position does not create a contractual obligation upon the Agency to continue this experience in the future. I agree that my volunteer experience is at-will and can be terminated by the Agency at any time. The reason for termination will be explained to me at termination. I also understand that I shall not be deemed an employee of Upstate Cerebral Palsy and that I will not be compensated monetarily for any volunteer services.

Signature: ___________________________ Date: ___________________________
Volunteer Health Assessment

Volunteer Name ________________________________________________________________

Mailing Address ________________________________________________________________

Telephone: Home ____________________________ Work ____________________________
Birth Date __________________________________ Sex: Male __________ Female _______

Emergency Contact ____________________________________________________________
Relationship ___________________________ Telephone: ______________ Work __________

Who is your regular health provider? ______________________________________________
Name ______________________________________________________________________

Telephone ________________________________

Please list any allergies _________________________________________________________

Please list any physician indicated restrictions ______________________________________

Will you need any accommodations (due to physical, emotional, or developmental disability, heart disease, back injury, etc..) in order to provide volunteer services?____________________
If yes, what kind of accommodations do you need?   __________________________________

I am not habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior. ____________________________________________________________

The statements herein are true to the best of my knowledge.

Signature of Volunteer _____________________________    Date _________________________

Please note: Assuring the safety and well-being of our consumers, staff, and volunteers is essential to the provision of services. Therefore, if after review of this health assessment the Volunteer Development office, upon advice from the Medical Director, determines that the safety and well-being of consumers, staff or volunteers are in jeopardy, the Volunteer Development office may request the prospective volunteer to submit a health report from their health provider before being placed in a volunteer position. If this is necessary, the costs associated with the health report will be borne by the volunteer.