



MAIN OFFICE: 1020 Mary Street, Utica, New York 13501
 Phone: (315)724-6907 ext. 2278 Fax: (315)798-8818
 Website: www.upstatecp.org

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)						
_____	_____ (Major)	1	2	3	4	Graduate
(College)						
_____	_____ (Major)	1	2	3	4	Graduate
(College)						

(Continued on reverse)

Rev. 2/29/12

Employment History

Employer	Position/Job Duties	Supervisor	Dates

Volunteer Experience

Agency	Responsibilities	Supervisor	Dates

Personal Information

Summarize skills and qualifications acquired from employment, volunteer, or life experiences.

Have you ever been convicted of a crime including misdemeanors and summary offenses? Yes No

Have you ever been convicted or entered a plea of no contest to charges of offense which involve abusing, neglecting, or mistreating children or adults? Yes No

*** If you answer "Yes" to either of these questions, you will need to describe the charges and resolution of the charges, in full, at the time of the interview.*

Personal References

Please list two references who are not related to you. *Use complete address with house or PO Box number.*

Name	Address	Telephone	Years Known

Will you allow us to contact you about future volunteer opportunities and upcoming events? Yes No

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.

Main Office: