VOLUNTEER APPLICATION

627 West Genesee Street Syracuse, NY 13204-2347
(315) 475-2430 FAX (315) 472-6515

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All information requested is kept strictly confidential.
Please complete all sections and return to the volunteer coordinator.
PLEASE PRINT.

Date of Application _____

Last Name _____ First Name _____ Chosen Name _____

Street _____ City _____ State _____ Zip Code _____

Home (_____) _____ Best time to call _____

Work/Cell (_____) _____ Best time to call _____

Email address _____@_____._____Birth date ____/_____/_____

If you have a resume that gives the following information, attach it and do not fill out what is already stated on your resume.

Volunteer Experience

Agency/Organization Dates Description of Work/Title

_____
_____
_____

Employment (optional)

Employer Dates Description of Work/Title

_____
_____
_____

Education (optional)

School Dates Degree/Major

_____
_____

Foreign languages spoken _____

Have you ever been convicted of a crime or violation other than a minor traffic infraction?
◯ NO ◯ YES
If yes, please explain: _____
_____

(A conviction record will not necessarily be a barrier to volunteering. Factors such as job relations, age, time of offense, seriousness and nature of violation and rehabilitation will be taken into account.)

Availability:

Monday	AM	PM	Friday	AM	PM
Tuesday	AM	PM	Saturday	AM	PM
Wednesday	AM	PM	Sunday	AM	PM
Thursday	AM	PM			

Would you like to receive our Agency mailings (newsletter, events, etc…)? ☐ YES ☐ NO

Please place two checkmarks next to the areas that you are very interested in volunteering and one checkmark next to the areas that you have some interest in. Leave the others blank.

*These areas require additional training beyond HIV/AIDS 101.

☐☐ Daytime office assistance: receptionist, housekeeping, clerical, data entry, mailings
☐☐ Intern/Service Learning: volunteering for college credit
☐☐ LGBTQ Youth Program (group facilitators, tutors, after school program)*
(Experience working with youth preferred)
☐☐ Fundraising: Be a part of our "event day" volunteer team or be the driving force behind our events by serving on the Special Events Committee (meets year-round).
☐☐ No-Hitch Luncheon Team: twice monthly luncheon, prepare and serve*
☐☐ Safety First Outreach Program Peer Associates for various Prevention Programs (qualifications and training specific to Program)*
☐☐ One-on-one support for clients, transportation, socialization, hospital visitation*
☐☐ Education and Community Outreach: distributing agency information; info booths
☐☐ Educators/Speakers (Persons with HIV/AIDS share your story to help educate)
☐☐ Professional Services: (your professional expertise)
Please explain: _____
☐☐ Be a Leader: Initiate food/personal care item/housecleaning supply drives at school, work or church
☐☐ Holiday Angel - Support an individual or family and spread the spirit of the holiday season

Comments:

Skills/experiences: What skills or experiences have you had that would benefit the volunteer program at ACR Health of Central New York (e.g. typing, computers, phone skills, professional work, public speaking, and counseling)? Or why does volunteering at ACR Health interest you? Use the reverse side of this page.

Pledge of Confidentiality

I, _____, am volunteering my time to work for ACR Health. I understand that in the course of my work for ACR Health, I may learn certain facts about other volunteers or individuals being served by ACR Health that are of a highly personal and confidential nature. Examples of such information are medical condition and treatment, finances, living arrangements, sexual orientation, employment, relations with family members and the like. I understand that all such information must be treated as completely confidential. In accordance with Public Health Law 27-F, I agree not to disclose any information of a personal and confidential nature to any person not also affiliated with ACR Health and authorized by ACR Health to have such information, without the specific consent of the individual to whom such information pertains.

VOLUNTEER

Print Name _____

Sign Name _____ Date _____

WITNESS

Print Name _____

Sign Name _____ Date _____

Copied to: _____
Date_____

EMERGENCY CONTACT INFORMATION

Volunteer/Peer/Intern Name: _____
print name

Start Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____

Relationship to Employee: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Is it OK to share this information with your volunteer program supervisor? ☐ yes ☐ no

Supervisor's Name (Print) : _____

Employee Signature: _____