VOLUNTEER APPLICATION

(315) 475-2430 FAX (315) 409-7178 volunteer@acrhealth.org

All information requested is kept strictly confidential.
Please complete all sections and return to the Volunteer Services Manager.

PLEASE PRINT. **Date of Application** _____

Name _____ **Chosen Name** _____ **Gender Pronouns** _____

Street _____ **City** _____ **State** _____ **Zip** _____

Home (_____) _____ **Best time to call** _____

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

Email address _____@_____._____ **DOB** ____/_____/_____

Volunteer Experience

Agency/Organization Dates Description of Work/Title

_____
_____
_____
_____
_____

Foreign languages spoken _____

Availability

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

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 agency orientation

____ 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: _____
____Holiday Angel: Support an individual or family during the winter holiday season

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Would you like to receive our Agency mailings (newsletter, events, etc…)? ___Yes ___No

Pledge of Confidentiality

I, _____, am volunteering my time to work at 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/INTERN/PEER

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 Volunteer/ Peer/Intern: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Is it OK to share this information with your volunteer program supervisor? _____yes _____no

Supervisor's Name (Print): _____

Volunteer/Peer/Intern Signature: _____