Volunteer Application

Name:____

Address: ____

City: _______________________ **State:** ________________ **Zip:** ________________

Home Phone #: (____) __________ **Cell Phone #** (___________) ______________________

Work Phone #: (____)__________ **E-mail:** _____________________________________

Know more than one language? (Please Circle) YES or NO
If yes, please specify_____________

Attending School? (Please Circle) YES or NO **Name of School** ______________________

What is your field of study? ____

Number of hours you wish to volunteer: ____

Date & Event you wish to volunteer for (circle one):

Monday _____	**Tuesday** _____	**Wednesday** _____	**Thursday** _____	**Friday** _____

Beginning Date: ______________ **Ending Date:** ________

How did you hear about Central Valley Children's Services Network?

School _____ **Newspaper** _______ **Friend** _____ **Flyer** ______ **Other** ___________

What are your interests? ____

____

Why did you select Central Valley Children's Services Network as a place you would like to volunteer?

____

____

What documentation at the end of the volunteer time is required of Central Valley Children's Services Network?

____

____

To be completed by CSN staff

Information received by: Mail _____ Telephone __________ Fax _____

Interview date: __________ By: ___________________________________

Assigned to: _________________ Department: _____Public Relations____

Beginning Date: ______________ Ending Date: _______________________

Times/Days each Week:

Mon________ Tues________ Wed________ Thurs________ Fri________

***Waiver: By signing I assume any risk and take full responsibility and waive any claim of personal injury or damages to any property associated with *(NAME OF EVENT)*event organized by CVCSN.org**

Signature:____Date: ______

Emergency Form

Name: ____

Address: ____

City: _____________________ **State:** ________________ **Zip:** _______________

Home Phone #: (____) __________ **Cell Phone #:** (_____) ___________________________

Work Phone: (__________) __________**E-mail:** ____________________________

Persons to be called in an Emergency:

Name: **Address:** **Phone #** **Relationship**

____

____

____

Physician: ____

Dentist: ____

If physician cannot be reached, what action should be taken?

______**Call Emergency Hospital**

______**Other** ____

Explain any special medical condition or medication: _________________________

____

Explain any allergic reactions to medication: ______________________________

____

What is your Blood Type? _______

Do you have health insurance? Yes ___________ **No** _________

If yes, Name: __________________________ **Policy#:** ___________________