VOLUNTEER APPLICATION

VOLUNTEER INFORMATION

Name _____

Date of Birth (Day, Month, Year) _____

Street Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Email _____

☐ New Volunteer ☐ Returning Volunteer

Do you meet the volunteer age requirement of 14 years old or older? ☐ Yes ☐ No

Do you require any special accommodations or adaptations to perform volunteer responsibilities? ☐ Yes ☐ No

If 'yes', please describe accommodations needed: _____

I prefer to volunteer at the following location:

☐ Ability KC Main Campus ☐ Ability KC Children's Center Campus ☐ No preference; please align me with the greatest area of need

I am interested in volunteering in:

☐ Adult Medical Rehabilitation
☐ Therapeutic Preschool
☐ Pediatric Medical Rehabilitation
☐ Administrative Departments
☐ Area of Greatest Need
☐ Peer Mentor **Must be previous patient or family member with referral letter from doctor or staff**

Languages spoken:

☐ English
☐ Spanish
☐ Chinese
☐ French
☐ German
☐ Other _____

Certifications: ☐ CPR ☐ First Aid ☐ N/A

Availability: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Hours available: ☐ Anytime ☐ Morning ☐ Afternoon

EMERGENCY CONTACT

Name _____

Relation _____ Phone (_____) _____

Other Information _____

_____

_____ _____

Volunteer's Signature Date

VOLUNTEER REQUIREMENTS

☐ Volunteer Waiver
☐ HIPAA Confidentiality Agreement
☐ Family Care Safety Registry Background Check
☐ TB Test
☐ Infectious Disease Health Screening Acknowledgement
☐ Marketing Authorization

Other Additional Requirement
☐ _____
☐ _____
☐ _____

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