



STUDENT VOLUNTEER APPLICATION

Mr. Mrs. Miss Ms. Rev. Dr.

Date ___/___/___

(Last Name)

(First Name)

(Middle Initial)

Preferred Mailing Address (Include number, street, city, state and zip code):

Home

Business

Cell

Phone: _____ Phone (if applicable): _____ Phone: _____

Email Address: _____

Educational Institution: _____

What course(s) are you applying your volunteer hours towards?

What skills/experience in working with adults with intellectual and developmental disabilities are you hoping to obtain while volunteering at Dawn of Hope?

How many volunteer hours are required? _____

Preferred date volunteer hours begin? _____

Preferred date volunteer hours conclude? _____

Weekly availability and preferred time?

<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>
8:30am – 2:30pm	8:30am – 2:30pm	8:30am – 2:30pm	8:30am – 2:30pm	8:30am – 2:30pm
Start: End:	Start: End:	Start: End:	Start: End:	Start: End:

Is it necessary for you to limit your physical activity in any way?

Yes No

If yes, what is your limitation?

Are you a licensed driver? Yes No

If yes, list any special endorsements, classifications o restrictions: _____

List previous experiences (volunteer, paid, or educational training):

Activity	Organization	Date
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Please give the name and number of person(s) who should be notified in the event of an emergency:

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

I understand that the above information is voluntarily supplied and may be used and disclosed for Dawn of Hope, Inc. purposes and, as a Dawn of Hope, Inc. volunteer, I will not be paid for my services.

(Signature)

(Date)