Volunteer Application for Bridges County Community Action Partnership
Administrative Office
232 N. Main Street, Suite G
Marysville, Ohio 43040
937-642-4986

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Name: ____________________________________________ Today’s Date: _________
Daytime Phone: ______________ Evening Phone: ______________ Other: ___________
Mailing Address: __________________________________________________________________
Email Address: _____________________________________________________________________
Where did you learn about becoming a Volunteer? _________________________________

Medical Information
In case of medical emergency notify ________________________________________________
Phone __________________ Address _________________________________________________
Relationship_________ Physician_________________________ Phone# _________________
Hospital Preferred __________________________________________________________________

Skills and Interests
Education Background_______________________________________________________________
Current occupation ________________________________________________________________
Hobbies, interests, skills ___________________________________________________________
Previous volunteer experience_______________________________________________________

Where would you prefer to volunteer?
(Job Descriptions for each position is available upon request)

_____ Receptionist  _____ Office Assistant
_____ Grounds Upkeep  _____ Indoor Facility Upkeep
_____ Mentoring Shelter Residents  _____ Tax Clinic Greeter
_____ Tax Clinic Preparer  _____ Tax Clinic Screener/Reviewer

Revised 9/8/2020
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What days and times are you available?

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References – Please name two people who we may contact for references. This can include one reference from a close friend or relative and one reference from a current or former employer, teacher/professional or person in authority.

Name:________________________ Telephone #:____________ Relationship:____________

Name:________________________ Telephone #:____________ Relationship:____________

If you have a medical condition and/or impairment which you feel may affect your volunteering, please give us a contact that has knowledge of your requirements.

Contact Name:________________________ Relationship to you:____________

Do you have any criminal convictions? _____ Yes _____ No
If yes, please give details: ____________________________________________________________

Volunteer Pledge of Confidentiality and Service
As a volunteer at BRIDGES, I pledge not to divulge, distribute or make public any client’s personal or financial information. I agree to do my duties to the highest degree of my ability and strive for accuracy and quality in all my actions. In addition, I agree that to the best of my knowledge, the information given by me is correct and I confirm that I do not object to the information collected on this form being held and used in the manner stated. I agree that Bridges Community Action, (BRIDGES) has the right to confirm any of the information provided.

Date:________________________ Volunteer Signature:________________________

Revised 9/8/2020