



Volunteer Application

Full Name:	
Street Address:	
City, State, Zip Code:	
Social Security Number:	
Home Phone:	
Work Phone:	
E-Mail Address:	
Date of Birth:	
How long have you lived in Ohio?	

Employment/Volunteer Experience:

Are you currently employed? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how many hours per week? _____	
Employer's name:	
Employer's phone number:	
Your duties in this position:	
Have you ever been employed by or done volunteer work for the Epilepsy Alliance? <input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, when:	
List all previous or current volunteer jobs:	
Do you have any experience working with children or people with disabilities? <input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, please describe:	

Volunteer Interest:

What type of volunteer job are you interested in?	
What draws you to volunteer with the Epilepsy Alliance?	
Do you have a geographical preference as to where you wish to do volunteer work? <input type="checkbox"/> yes <input type="checkbox"/> no	
If yes, where?	
What days and hours do you prefer to volunteer?	

Special Skills or Hobbies:

Summarize any special skills, training or interests that you may have (ex: computer skills, musical abilities, hobbies, etc.):		
Do you have a current First Aid Certification?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, expiration date: _____
Do you have a current CPR Certification?	<input type="checkbox"/> yes <input type="checkbox"/> no	If yes, expiration date: _____

Educational Background:

High School:
College, if applicable:
Are you earning service hours as a graduation requirement? <input type="checkbox"/> yes <input type="checkbox"/> no
If yes, name of coordinator of school service requirements: _____

Referral Source:

How did you hear about our organization? <input type="checkbox"/> Ad <input type="checkbox"/> Agency Client <input type="checkbox"/> Friend <input type="checkbox"/> Volunteer <input type="checkbox"/> Employee <input type="checkbox"/> Other: _____

Character References:

List 2 people (not related to you) and their complete address. (Work or volunteer references preferred.)					
1.					
2.	Name	Address	City, State, Zip	Phone	Relationship

Person to notify in case of emergency:

Name:
Phone number(s):

Have you ever been convicted of any felony or misdemeanor other than a minor traffic violation?
yes no if yes, please explain: _____

Agreement and Signature:

By submitting this application, I affirm that the facts set forth in it are true and complete. I verify that I have read and understand all questions on this application. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

I understand that I am applying to be a volunteer, and I do not expect to be paid.

Name (printed):
Signature:
Date:

By signing below, I agree to keep confidential any and all personal information of a sensitive nature pertaining to the Epilepsy Alliance Ohio.

I also agree to have a background check done if requested.

_____ Signature _____ Date

Our Policy

It is the policy of the Epilepsy Alliance Ohio to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age or disability.

Please return form to:

Epilepsy Alliance Ohio 895 Central Avenue, Suite
 550 Cincinnati, OH 45202
 (Fax: 513-721-0799)

Email: eao@epilepsy-ohio.org

Thank you for completing this application and for your interest in volunteering with us.