

LEGACY HOUSE / WISHARD HEALTH SERVICES

VOLUNTEER SERVICE APPLICATION

Please return to:

Legacy House

2505 North Arlington Avenue

Indianapolis, IN 46218

Questions – call: (317) 554-5272

(Opportunities for volunteers at Legacy House and Wishard Health Services are provided without regard to religion, creed, race, national origin, financial status, sexual orientation, age, gender or disability.)

Name: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Are you under 18 years of age? _____ Yes _____ No

Employer: _____ Work Phone: _____

Position & Major Responsibilities:

In case of illness or emergency, whom would you wish us to notify?

Name: _____ Home Phone: _____

Relationship: _____ Work Phone: _____ Pager/Cellular: _____

Availability: Schedule Preference Approximate Hours per:

Morning MTWTFSS _____ Regular Week: _____

Afternoon MTWTFSS _____ Special Events Month: _____

Evening MTWTFSS _____ Both/Either Date can begin: _____

Education:

_____ High School _____ Tech./Trade School _____ College Grad. _____ Attending College

If currently attending Trade School or College, area of study: _____

Degree(s) / Licenses / Certification:

What type of volunteer experience are you interested in?

_____ Client Interaction _____ Speaker's Bureau _____ Fundraising / Special Events

(Community Education)

_____ Office / Clerical _____ Working with Children _____ Other _____

Why do you wish to volunteer at Legacy House? _____

List special skills, interests, hobbies: _____

Previous Volunteer Experience:

Organization Name: _____ Telephone Number: _____

Volunteer Position: _____ Supervisor's Name: _____

Date of Service: _____ Describe volunteer duties: _____

REFERENCES: (Please do not include relatives.)

NAME	JOB TITLE	ADDRESS	PHONE #	RELATIONSHIP

Have you ever been convicted of a criminal case more serious than a minor traffic violation? ___Yes ___No

If yes, specify date, charge, place and action taken. _____

I consent to the release of any record of criminal convictions by any law enforcement agency to Legacy House and Wishard Health Services.

I certify that the information in this application is true. I understand that falsification of any information in this application can lead to my termination and that Legacy House and/or Wishard Health Services may verify the information on this application. I will not hold any person or organization liable for releasing such information to Legacy House and/or Wishard Health Services.

Applicant's signature: _____ Date: _____

Parent / Guardian signature (for ages 14 – 17)

Signed: _____ Date: _____