

**SARNIA-LAMBTON REBOUND - A PROGRAM FOR YOUTH, INC.**

**VOLUNTEER INFORMATION FORM**

**NAME:** \_\_\_\_\_  
Last First Initial Dr. Mr. Mrs. Miss Ms.

**OCCUPATION:** \_\_\_\_\_ **AGE:** If under 21, state age: \_\_\_\_\_  
If over, circle age group:

**SPOUSE'S NAME:** \_\_\_\_\_ 21-29 30-39 40-49 50-54 55+

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**HOME ADDRESS:** \_\_\_\_\_  
Street Apartment Number  
Ontario  
City Province Postal Code

**PHONE:** \_\_\_\_\_ When is the best time to call? \_\_\_\_\_

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**PLACE OF BUSINESS:** \_\_\_\_\_

**BUSINESS ADDRESS:** \_\_\_\_\_  
Street Suite Number  
Ontario  
City Province Postal Code

**PHONE:** \_\_\_\_\_ Can we call you at work? Yes \_\_\_\_\_ No \_\_\_\_\_

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**PLEASE LIST ALL YOUR CURRENT AND PAST VOLUNTEER POSITIONS AND EXPERIENCES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(over)

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**PLEASE PROVIDE TWO REFERENCES:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: (i.e. spouse, mother, etc.) \_\_\_\_\_

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**MEDICAL INFORMATION:**

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any medical conditions or other limitations we should know about? \_\_\_\_\_

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**WHERE DID YOU HEAR ABOUT OUR ORGANIZATION?** \_\_\_\_\_

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**WHAT AREAS WITHIN THE ORGANIZATION WOULD YOU BE INTERESTED IN VOLUNTEERING FOR?**

- SOCIAL SKILL PROGRAM IN EVENINGS
- S.A.F.E. CHOICES DRUG PROGRAM IN EVENINGS
- PARENT TRAINING PROGRAMS IN EVENINGS
- P.A.S.S. PROGRAM DURING DAYS
- FUNDRAISING
- YOUTH JUSTICE FORUMS

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I acknowledge and understand that this is an application to participate in a *volunteer* program for which there will be no financial compensation, and that attendance and work done by the volunteer at Rebound for the purposes of the program will be at the sole risk and expense of the volunteer.

\_\_\_\_\_  
Volunteer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Volunteer Coordinator's Signature

\_\_\_\_\_  
Date