Volunteer Service Application

Full Name: (Mr. Mrs. Ms) _____

Mailing Address: _____

Email Address: _____ Birthday: _____

Employer (please list your area of expertise, regardless of employment status):

_____

_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Fax Number: _____

Emergency Contact
Name/Relationship/Number: _____

May we call you at work: Yes No
May we leave a Hands of Hope Clinic, Inc. message at your work? Yes No
May we leave a Hands of Hope Clinic, Inc. message at your home? Yes No

Program(s) you would like to work with:

Please list any languages you are proficient in besides English._____

What ***days*** and ***times*** are you available to volunteer for Hands of Hope Clinic, Inc.?
Please list specific hours as well as days.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

If you are a licensed professional, please indicate professional license type and license number.
Type: _____

License #: _____ Expires on: _____

(770) 507-1344; Fax No. (770) 507-1377
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Reference 1:
Name: _____ Phone #_____

Relationship ***(no family members, please)*** _____

Reference 2:
Name: _____Phone#_____

Relationship ***(no family members, please)*** _____

Have you ever been convicted of a crime? (You may omit minor traffic offenses)

___yes ___no if yes, please explain
_____

If yes, was the conviction in Georgia or in another state? Please specify state(s)
_____

Advisory: A check of the volunteer applicant's criminal history may be made to verify the responses to the above questions for the sole purpose of ensuring the safety of its staff, volunteers and visitors. No applicant will be denied volunteer status solely on the grounds of conviction of a crime. The nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position will be considered.

As a volunteer/intern with The Hands of Hope Clinic, Inc., I understand that compliance with all of the requirements below is mandatory for everyone volunteering with HANDS OF HOPE CLINIC, INC. (including minors).

1. I understand that HANDS OF HOPE CLINIC, INC. has my permission to use my **name and photographs** of me to promote the organization.
2. I will inform a HANDS OF HOPE CLINIC, INC. Staff Member or the Volunteer Supervisor of any **previous injuries** that may affect my ability to safely complete volunteer tasks, including lifting.
3. I understand that I must carry my own **health insurance**. I will not hold HANDS OF HOPE CLINIC, INC. responsible for any unforeseen injuries or problems that may occur on the job.

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4. I understand I may not initiate or engage in any **media/public event** pertaining to individuals or the organization without the approval of HANDS OF HOPE CLINIC, INC... Requests for media engagements will be referred directly to HANDS OF HOPE CLINIC, INC. Staff or Volunteer Supervisor.
5. I understand I may not use the **HANDS OF HOPE CLINIC, INC. logo** without consent from the Executive Director.
6. I understand that I have the right to **submit a grievance** to the Executive Director of HANDS OF HOPE CLINIC, INC. should I not be satisfied with the response to the needs of, the interaction with, guidance of, care for patients within the scope of HANDS OF HOPE CLINIC, INC. mission.
7. **Many clients choose not to have their photos taken for personal and/or security reasons. I understand that I may NOT photograph nor arrange a photograph of groups or individuals without first receiving approval from HANDS OF HOPE CLINIC, INC. Staff or a Volunteer Supervisor to ensure HANDS OF HOPE CLINIC, INC. has obtained expressed written consent on a HANDS OF HOPE CLINIC, INC. consent form.**
8. I understand all individuals are to be treated with dignity, respect and consideration and are not **to be discriminated against** based on race, national origin, religion, gender, sexual orientation, age, disability or marital status.
9. I understand that the terms listed above are **not all-inclusive** and may be updated, as needed.

All persons participating in HANDS OF HOPE CLINIC, INC. volunteer activities agree to the terms and conditions in this agreement.

"I certify that all information submitted by me on this application is true and complete. I understand that if any false information, omissions, or misrepresentations are discovered, my application may be rejected and active volunteer status may be terminated at any time. In consideration of my volunteer application, I agree to adhere to the policies and regulations of Hands of Hope Clinic, Inc., and I agree that my volunteer status can be terminated, with or without cause, and with or without notice, at any time by Hands of Hope Clinic, Inc."

Signature: _____Date _____
(Print and Sign)

Witnessed by: _____Date _____
(Print and Sign)

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