BRAIN INJURY RESOURCE CENTER of Wisconsin

VOLUNTEER APPLICATION (Print Clearly)

Name:	Date of Application:
Address:	
City:	State & Zip:
Telephone (day):	Evening or Cell:
Email:	Birthday Month (no year):

EMERGENCY CONTACT

Name:	Relationship:
Telephone (day):	Evening or Cell:

VOLUNTEER EXPERIENCE (list places where you have served as a volunteer and duties performed)

EDUCATION CREDIT

Are you currently attending school? ☐ Yes ☐ No
If so, will you receive academic credit for your volunteer work? ☐ Yes ☐ No

CRIMINAL BACKGROUND (Background checks may be performed)

Have you ever been convicted of a crime, not including traffic? ☐ Yes ☐ No

REFERENCES

Name:	Telephone:
Relationship:	
Name:	Telephone:
Relationship:	

AVAILABILITY FOR VOLUNTEERING (Check all that apply)

☐ TUE	☐ WED	☐ THUR
☐ 1:00 – 1:30	☐ 1:00 – 1:30	☐ 1:00 – 1:30
☐ 1:30 – 2:00	☐ 1:30 – 2:00	☐ 1:30 – 2:00
☐ 2:00 – 2:30	☐ 2:00 – 2:30	☐ 2:00 – 2:30
☐ 2:30 – 3:00	☐ 2:30 – 3:00	☐ 2:30 – 3:00
☐ 3:00 – 3:30	☐ 3:00 – 3:30	☐ 3:00 – 3:30
☐ 3:30 – 4:00	☐ 3:30 – 4:00	☐ 3:30 – 4:00
☐ 4:00 – 4:30	☐ 4:00 – 4:30	☐ 4:00 – 4:30
☐ 4:30 – 5:00	☐ 4:30 – 5:00	☐ 4:30 – 5:00

VOLUNTEERING OPPORTUNITIES(Check all that apply)

☐ Receptionist	☐ Event Staff	☐ Resource Facilitation II	☐ Sales
☐ Social Programs Coordination	☐ Gift Shop	☐ Fundraising	☐ PR and Marketing

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PLEDGE OF CONFIDENTIALITY

This is to certify that I (an employee, intern, volunteer, speaker, mentor or Board member of Brain Injury Resource Center of Wisconsin, Inc.) understand that any information (written, verbal or other form) obtained during the performance of my duties must remain confidential. This includes all information about members, clients, families, employees and other associate organizations, as well as any other information otherwise marked or known to be confidential. I understand that any unauthorized release or carelessness in the handling of this confidential information is considered a breach of the duty to maintain confidentiality. I further understand that any breach of the duty to maintain confidentiality could be grounds for immediate dismissal and/or possible liability in any legal action arising from such breach.

My signature below certifies that all statements made on this application are true, complete, and correct to the best of my knowledge and belief. I understand these statements are subject to verification. I also understand that falsification of this application can disqualify me from consideration or result in dismissal upon discovery. I understand that submitting this information does not guarantee my acceptance into the volunteer program, and that assignment of volunteer work is based on assessments made by Brain Injury Resource Center of Wisconsin staff.

I grant the Brain Injury Resource Center of Wisconsin permission to contact the references listed on this application in order to determine suitability for volunteer placement. Finally, I understand that as a volunteer, I will be required to abide by all rules and regulations of Brain Injury Resource Center of Wisconsin. Volunteers are considered for placement without regard to actual or perceived race, color, religion, sex, national origin, or ancestry, age, disability, veteran status, sexual orientation, marital status, status with respect to receipt of public assistance, or any other basis protected by federal, state, or local law.

Signature:

Fax Completed Form to: 262-436-1747
Mail Completed Form to: BIRCofWI, P.O. Box 808, Muskego, WI 53150-0808
Email Completed Form to: Admin@bircofwi.org

For Office Use Only:
Date Received: _____ Volunteer Start Date: _____