Submit by E-mail Print Form

If using **CHROME,** please download this document to your computer and email the filled out application to **Marybellamy@placeofhoperinker.org.**

Volunteer Application

The Leighan and
David Rinker Campus

"Seek justice. Encourage the oppressed. Defend the cause of the fatherless..."
Isaiah 1:17

Thank you for taking the time to complete this form. Please know that the included information will be kept confidential and will only be shared with our appropriate staff. We are looking forward to knowing you!

Once you have completed this packet, please e-mail or return it to the Place of Hope office and save a copy for your records.

Place of Hope
at The Leighan and David Rinker Campus
21441 Boca Rio Road
Boca Raton, FL 33433

If you have any questions, please don't hesitate to give us a call at 561.483.0962.

General Information

First Name: Last Name:

Title: Dr. Mr. Mrs. Ms. Other: Gender: M F

Date: Date of Birth:

Occupation: Status: Full-Time Part-Time Student

Place of Employment: Type of Business:

Business Address:

Business Phone:

Address History for Past Five Years

Current Address:

City: State: Zip Code:

Previous Address: Years/Months:

City: State: Zip Code:

Previous Address: Years/Months:

City: State: Zip Code:

Home Phone: Cell Phone:

Email: Preferred Contract: Phone E-mail

Emergency Contact: Relationship:

Emergency Contact Phone:

With which Program(s) are you interested in volunteering?

- Family Cottages
- Emergency Shelter
- Life-Skills Training
- Health & Wellness Center
- Hope Campaign
- Advancement/Fundraising
- Office
- Other

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In what areas are you interested in volunteering?

- Administrative/Mailings
- Clerical
- Construction/Handyman
- Dental
- Educational - Tutoring
- Fundraising
- Furniture Pick-Up
- Housekeeping/Cleaning
- Independent Living
- Legal
- Life-Skills Classes
- Meals/Cooking
- Medical
- Mentoring
- Music
- Providing Employment
- Special Event Help
- Sports Day
- Other

Please give any additional details as to your specific volunteer interests:

If you are looking to volunteer directly with children, do you have age/gender preferences?

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Personal Information

The integrity and quality of care we provide to our kids is a top priority. To help us ensure we are providing the best care possible to our kids, please provide us with two non-family personal references that you have known for a minimum of two years.

Reference 1

Name:

Primary Phone:

Email:

Relationship:

Number of Years Known:

Reference 2

Name:

Primary Phone:

Email:

Relationship:

Number of Years Known:

Please list any training, education, licensing or certifications that could help you in volunteering. Please include First Aid/CPR, Lifeguard, CPI, etc. (this is not a prerequisite for volunteer approval):

Hobbies, special interests or talents:

How did you hear about us and become interested in volunteering?

I understand that a routine fingerprint and background check will be required of all persons providing services to Place of Hope, as it relates to childcare.

I consent to deny this screening

Office Use Only

LabCorp_____ Live Scan_____

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As a volunteer, I understand that I will not reveal any confidential information learned or obtained while fulfilling agreed functions. I also agree to represent this organization with the highest degree of integrity, professionalism and honesty at all times.

Confidentiality Statement

Volunteers/Visitors

I, the undersigned, understand and agree to all terms of confidentiality set forth in this agreement, upon entrance to and visitation of Place of Hope and its programs, participants and staff.

- All information learned by me, either oral or written, shall remain confidential and is regarded as confidential information subject to State and Federal laws that protect the rights and privileges of clients and client information in licensed facilities.
- All information with regard to any client, including any group participation and information shared, is confidential and should only be shared with Place of Hope staff or those deemed appropriate by the Place of Hope administration for the purpose of fulfilling responsibilities directly related to my visit or contact. **Any discussions outside of this responsibility, or that which is authorized by State and Federal law, will be deemed a Breach of Confidentiality.**
- A Breach of Confidentiality may result in dismissal of privileges for further visitation or contact with Place of Hope, its programs, participants and staff. I will also be subject to State and Federal regulations and law, which could include fines and/or imprisonment to include additional reporting to appropriate professional licensing boards and authorities.

I have read, understood and agree to comply with this statement. If I submit this form online, I understand that I may be asked to provide my signature at a later date.

Print Name

Agency (If Applicable)

Address

Signature

City, State, Zip

Witness

Phone Number

Date

Submit by E-mail

Print Form