VOLUNTEER APPLICATION

Please fill out the following completely and accurately.
Email to: Info@bridgingbionics.org

Date:

VOLUNTEER

Name: _____

Age: _____ Date of Birth: _____/_____/_____

Address: _____

_____

_____

Home phone: _____

Cell phone: _____

Email address: _____

Gender: Male ☐ Female ☐

Height: _____ Weight: _____lbs.

Primary language spoken/understood: _____

Other languages spoken/understood: _____

_____

Have you worked with people with disabilities? Yes ☐ No ☐

If yes, please describe your experience:

_____

_____

_____

_____

_____

_____

Do you have any First Aid training? Yes ☐ No ☐
If yes, please describe: _____

_____

_____

Volunteering for our program can be physically demanding and may require lifting equipment and assisting with lifting clients to help them transfer into the equipment.

Do you have any physical limitations? Yes ☐ No ☐
If yes, please describe: _____

_____

_____

Can you lift more than 50 lbs? Yes ☐ No ☐

Do you have cognitive challenges that we need to consider when assisting clients? Yes ☐ No ☐
If yes, please describe: _____

_____

EMERGENCY CONTACT INFORMATION

(if different from Parent/Guardian)

Name: _____

Relation: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Primary language spoken/understood: _____

Program Assistant Volunteers will be required to attend mandatory trainings to learn how to assist clients with equipment.

Are you available weekdays to volunteer for our Mobility Program? Yes ☐ No ☐

If yes, please identify which days are most suitable for you? _____

_____

Would you be willing to assist with: (Please check all that apply)

- ☐ Special Events
- ☐ Fundraising
- ☐ Administrative / Office Assistance (data base entry, scheduling etc.)

Please make us aware of any other skills that you have that could be helpful for our organization: _____

_____

_____

_____

Volunteers are an essential part of Bridging Bionics Foundation. Our program assistant volunteers will learn how to safely assist, support and accommodate the needs of our clients who have mobility impairments, while working under the guidance of a trained physical therapist. Please sign that the information you have provided is current and accurate. We appreciate your support.

Volunteer's Signature: _____ Date: _____

Volunteer's Name (Please print): _____