Volunteer Application

Date of Application: _____

Contact Information

Name _____
Last First Middle

Address _____
Street City State Zip

Day Phone Number_____ **Evening Phone Number**_____

E-mail Address _____

Group Name (Company or civic group) _____

Self Screen Eligibility Check List

Please review the following check list to determine your eligibility:

- ☐ I am 18 years of age or older
- ☐ I am under the age of 18 – I understand I must have an adult with me and my parent/guardian must sign this form.
- ☐ I have not utilized the Waypoint Domestic Violence, Sexual Assault, Madge Phillips Shelter or Daytime Resource Program within the past year.
- ☐ I have no history of founded child or adult abuse.

Have you ever been convicted of a crime, other than a minor traffic offense?
(Conviction of a crime will not necessarily disqualify you from volunteering with us. Lying about it will.)

_____No _____Yes*

*Date of offense & please describe_____

General Information

Have you ever volunteered at Waypoint, formerly the YWCA, before? _____Yes _____No

If yes, please give dates and activities_____

Names of relatives or friends that work or volunteer at Waypoint_____

Why do you want to volunteer at Waypoint? _____

_____

_____

Please check the areas you wish to volunteer for:

_____ Food Pantry Support
_____ Domestic Violence and Sexual Assault Advocacy
_____ Program activities (please check box)
- ☐ *May Day Basket Supply Distribution*
- ☐ *Back to School Supply Distribution*
- ☐ *Waypoint Wonderland Holiday Gift Distribution*

_____ Quarterly deep cleaning of Waypoint facilities
_____Serve on a Waypoint Committee – List committee _____

Emergency Contact Information

In case of an emergency, Waypoint should contact:

Name_____Relationship_____

Phone Number_____

Education and Training

Please circle highest year of education completed:

Elementary/Middle/High School: 1 2 3 4 5 6 7 8 9 10 11 12 College: 13 14 15 16 17 18 19 20

List any education, training, or skills that you would like to share with Waypoint

_____

_____

Consent/Release

I understand that:

- Waypoint Services can perform a background check on me. _____
  Date of Birth _____ ***Initial here***
- Waypoint Services is not obligated to accept me as a volunteer. _____
  Initial here

I CERTIFY that the statements herein are correct and true to the best of my knowledge.

_____	_____	_____
Volunteer Printed Name	**Volunteer Signature**	**Date**

Confidentiality Agreement

It is the policy of Waypoint to hold confidential all observations and information made by and between or about Waypoint clients and program participants. Also confidential are all conversations between employees and volunteers. All Waypoint staff, interns and volunteers are subject to this policy. Furthermore, the employment, residence, phone number, and family addresses of clients, staff and volunteers are not to be disclosed except with the explicit written permission of the individual involved. I agree to follow the Waypoint policy of confidentiality. I also understand the Waypoint Domestic Violence and Sexual Assault Programs policy reflects Iowa Code Chapter 915-20A. I understand that this agreement will be placed in my volunteer file and that a violation of this policy may result in disciplinary and/or legal action.

_____	_____	_____
Volunteer Printed Name	**Volunteer Signature**	**Date**

Parental Consent – If under the age of 18

I _____warrant that I am the parent/legal guardian of _____.

(name of parent/guardian) *(name of child—"child")*

I understand that my child has the intentions to volunteer at Waypoint Services and agree with his/her participation. I understand that my child is expected to abide by any rules/regulations set by Waypoint Services. I understand that during the time spent volunteering at Waypoint Services I am responsible for ensuring an adult, not employed by Waypoint Services, is present to supervise my child. I further understand that I am responsible for providing all transportation for my child. In the event of an accident or injury I authorize Waypoint Services to seek and obtain medical treatment and care for my child.

_____	_____	_____
Parent/Guardian's Printed Name	**Parent/Guardian's Signature**	**Date**