

Volunteer Application Form



Name: _____ Date of Birth: _____

Address: _____

Home Tel: _____ Mobile: _____

Work Tel: _____

Email: _____

How would you like us to contact you: e-mail post phone

Who to contact in an emergency:
Telephone no: _____

Please tell us why you want to become a volunteer?

Do you have any hobbies, skills or interests?

What service are you interested in getting involved in? (please tick as many boxes as needed)

LINK

PAPOP

PIPS

Carers Champions

Colebrook Management Committee

When would you be available to volunteer?

Flexible

Prefer Week Days Prefer Weekends

Prefer Daytime

Prefer Evenings Other: please specify

Do you have a disability or mobility issue?

NO Yes (please give details)

Do you have any health issues or take any medication you think we should know about? (Please tell us about these)

Do you drive (i.e.: do you have a car) Yes

No

Name and address of 2 referees

Name	
Address	
Contact No:	
Position or relationship:	

Name	
Address	
Contact No:	
Position or relationship:	

If you would like this information in another language or format (e.g. large print)

Please contact LINK 01752 202406/7

Email info@plymouth-link.co.uk

www.plymouth-link.co.uk

I confirm that the information given on this form is true and accurate. I will tell you if any of the information I have given changes. I understand that if any information is found to be incorrect or untrue this may prevent me from volunteering.

Signed _____

Dated _____

Please email to info@plymouth-link.co.uk or send to Unit 15, HQ Building, 237 Union Street, Plymouth, PL1 3HQ.

Thank you for your interest!

EQUALITY & DIVERSITY MONITORING

We are strongly committed to an ethos of equality and non discrimination within all areas of our work and aim to positively value individuals.

To help monitor use of this policy we would be grateful if you would complete this form.

This page of your application form will be detached immediately upon receipt, will be kept confidential and will only be used for monitoring purposes.

1. Are you Male female

2. Do you consider yourself to be disabled? Yes / No

3. What is your age group? Please tick.

25 and under	<input type="checkbox"/>	40 - 55	<input type="checkbox"/>
26 - 39	<input type="checkbox"/>	56 - 65	<input type="checkbox"/>
Over 65	<input type="checkbox"/>		

2. What do you consider to be your Ethnic Origin? (*Please tick ✓*)

Black British	<input type="checkbox"/>	Turkish	<input type="checkbox"/>
Black African Caribbean	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Black Irish	<input type="checkbox"/>
Black Other	<input type="checkbox"/>	White Irish	<input type="checkbox"/>
Asian Indian	<input type="checkbox"/>	White	<input type="checkbox"/>
Asian Other	<input type="checkbox"/>	White Other	<input type="checkbox"/>
Greek	<input type="checkbox"/>	Other (specify) _____	

Thank you