

Please return form to: **Office**

1018 South Taylor Drive, Sheboygan, WI 53081

Anchor of Hope Health Center Confidential Application for Volunteers

Date of Application: _____

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone: _____ Language(s) spoken besides English: _____

How did you hear about us? _____

Occupation(s) past and present: _____

Home Church: _____ Pastor's Name: _____

Church Address: _____

Church Phone: _____

Do you consider yourself a Christian? _____ Yes _____ No If yes, please explain: _____

What areas have you or do you serve within your church? _____

What gifts and skills do you have that might benefit AOH? _____

Briefly describe why you are interested in volunteering at Anchor of Hope? _____

Describe any volunteering that you have done for others: _____

_____ Please list
the times you would be willing to volunteer:

Monday

Tuesday

Wednesday

Thursday

Friday

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Please list an individual in church leadership who we may contact for a reference:

Name: _____ **Position:** _____

Address: _____

Email Address: _____ **Phone number:** _____

Please list two individuals, not related to you, who you have known for at least one year, who we may contact as a character reference on your behalf.

1) Name: _____ **Relationship:** _____

Address: _____

Email Address: _____ **Phone number:** _____

2) Name: _____ **Relationship:** _____

Address: _____

Email Address: _____ **Phone number:** _____

Anchor of Hope is a pro-life center. Please explain any circumstances that you feel abortion is justified: _____

Do you agree with the following Mission Statement of Anchor of Hope? _____ Yes _____ No

Anchor of Hope is a life-affirming clinic encouraging healthy sexual choices, sharing the hope, compassion, and truth found in Jesus.

Do you agree with the following Vision Statement of Anchor of Hope? _____ Yes _____ No

Our vision is a culture where lives are transformed by the Gospel of Jesus Christ and Human life is deemed sacred and affirmed by all.

Additional information you wish us to know: _____

Center Medical/Insurance Waiver:

I understand that Anchor of Hope does not carry insurance that covers injury to a volunteer.

_____ I carry adequate medical insurance, and I accept full responsibility for medical costs associated with an injury while volunteering at Anchor of Hope.

Name of Insurance Carrier: _____ Policy Number: _____

_____ I do not carry medical insurance, and I accept full responsibility for medical costs associated with an injury while volunteering at Anchor of Hope.

Please read the following carefully before signing this application: I understand that this is an application for and not a commitment or promise of volunteer opportunity. I certify that I have and will provide information throughout the selection process, including on this application for a volunteer position and in interviews with Anchor of Hope Health Center that are true, correct, and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have not and will not withhold any information that would unfavorably affect my application for a volunteer position. I understand that information on my application will be confirmed by AOH. I understand that a background check may be done before I begin my volunteer service with AOH. I understand that misrepresentation or omissions may be cause for my immediate rejection as an applicant for a position with Anchor of Hope or my termination as a volunteer.

Signature: _____

Date: _____