Please mail form to: **Office at** 1018 S Taylor Drive, Sheboygan, WI 53081
or email to: hope@anchorofhopewi.org

Anchor of Hope Health Center

Confidential Application for Volunteers

Date of Application: _____ **DOB:** _____

Name: _____

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

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

Name: _____ **Position:**_____

Address: _____

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

Please circle your areas of interest:

Client Mentor	**Reception/Data Entry**	**Boutique (onsite 'store') Helper**
Prayer Team	**Medical (Nurse, NP, or Physician)**	**Banquet & Events**
Finance/Fundraising	**Post Abortive Support**	**General (letter stuffing, cleaning, etc.)**

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. Please provide the complete address.

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:

_____

_____

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 of 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: _____