



## Adult Volunteer Application

### General Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SSN: \_\_\_\_\_ Email: \_\_\_\_\_

(Required for background check)

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

State(s) of residency (last 5 years): \_\_\_\_\_ Years of residency: \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: Home \_\_\_\_\_ Mobile: \_\_\_\_\_ Work \_\_\_\_\_

### Employment Information

Current/most recent employer: \_\_\_\_\_

Job title/Duties: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_

### Education and Training

Last formal education (name of school and course of study): \_\_\_\_\_

Other training or certifications \_\_\_\_\_

### Volunteer Experience

Organization(s): \_\_\_\_\_

Volunteer duties: \_\_\_\_\_ Dates of service: \_\_\_\_\_

### Medical Information

*Please provide documentation of the following medical requirements:*

1. **1-StepTB Clearance:** negative PPD or chest xray current within one year of this application. 2-Step PPD required for hospital visitations.
2. **MMR vaccine** or positive titre blood test or physician statement of previous disease.
3. **Varicella vaccine** or positive Varicella (chicken pox) titre blood test or physician statement of previous disease.

### Volunteer Interests

*Please check your area(s) of interest in volunteering at HUGS:*

**Family Programs-** Interact with and provide care to **HUGS** children and their families.

\_\_\_ Respite      \_\_\_ Family Dinner      \_\_\_ Sibling Camp

\_\_\_ **Office Support:** Assist **HUGS** staff with computer data entry, phone calls, mailings and office maintenance.  
Office hours are M-F 8am-5pm.

\_\_\_ **Special Events:** Assist with community outreach and fundraising events.



**Additional Information**

How did you learn about the **HUGS** volunteer program? \_\_\_\_\_

\_\_\_\_\_

Why do you want to become a **HUGS** volunteer? \_\_\_\_\_

\_\_\_\_\_

Do you have any limitations (physical/other) that **HUGS** should be made aware which may impact your ability to successfully volunteer in specific capacities? \_\_\_\_ Yes \_\_\_\_ No If yes, please explain:

\_\_\_\_\_

Do you have been convicted of a criminal offense crime? If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**References**

Please list two (2) individuals who reside in Hawaii, are not family members, have knowledge of your qualifications and whom HUGS may have your authorization to contact.

Name	Where employed/Occupation	Best daytime phone #
1. _____	_____	_____
2. _____	_____	_____

*I certify that all statements made in this application are true. I understand that if I am accepted as a **HUGS** volunteer, any false statements made on this application or failure to provide requested information shall be considered sufficient cause for my dismissal from this volunteer program. I agree to have a reference check and criminal conviction check performed by HUGS and its designated screening agency, Pre-Employment Services Hawaii, LLC. I agree to abide by all **HUGS** policies and rules relating to the volunteer program.*

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

Please sign and submit this application via email: [volunteer@hugslove.org](mailto:volunteer@hugslove.org); fax(808) 732-4881; or mail:

**HUGS**  
3636 Kilauea Avenue  
Honolulu, Hawaii 96816

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VOLUNTEER OFFICE USE ONLY:

Date rec'd \_\_\_\_\_ Bkg chk sent \_\_\_\_\_ Bkg chk \_\_\_\_\_ Ref chk A. \_\_\_\_\_ B. \_\_\_\_\_ Agrm/Rel \_\_\_\_\_

TB clearance: Step 1 \_\_\_\_\_; Step 2 \_\_\_\_\_; MMR \_\_\_\_\_; Varicella \_\_\_\_\_

Training \_\_\_\_\_ Photo ID \_\_\_\_\_