PLYMOUTH AREA COALITION
FOR THE HOMELESS

VOLUNTEER APPLICATION

DATE: _____ *BIRTHDATE:*_____ *EMAIL:*_____

NAME: _____
LAST *FIRST* *MIDDLE OR INITIAL*

ADDRESS: _____
STREET *CITY* *ZIP*

PHONE: _____

OCCUPATION: _____

EMPLOYER: _____

EDUCATION:
COLLEGE: _____ *GRAD. YEAR:* _____

AREA OF STUDY: _____ *DEGREE:* _____

TRAINING SCHOOL: _____ *GRAD YEAR:* _____

HIGH SCHOOL: _____ *GRAD YEAR:* _____

LIST 2 MOST RECENT EMPLOYMENT POSITIONS:
Company/Organization *Position* *Dates*

1. _____

2. _____

MOST RECENT VOLUNTEER POSITION:

Organization *Position* *Dates*

1. _____

2. _____

3. _____

*SKILLS, INTERESTS, HOBBIES:*_____

*FOREIGN LANGUAGE:*_____

*HOW DID YOU LEARN ABOUT OUR OFFICE:*_____

*DAYS AND HOURS YOU WOULD BE AVAILABLE:*_____

*IN WHICH PROGRAM ARE YOU INTERESTED:*_____

REFERENCES: *Three people (other than relatives) whom we may contact. If you are a student, list your advisor or faculty member.*

	NAME	*ADDRESS*	*TELEPHONE*
1.	_____		
2.	_____		
3.	_____		

IN CASE OF EMERGENCY NOTIFY:

	NAME	*RELATIONSHIP*	*TELEPHONE*
1.	_____		
2.	_____		

SIGNATURE _____ *DATE* _____

VOLUNTEER MEDICAL INFORMATION FORM

Do you have a history of epilepsy: yes/no *Are you a diabetic: yes/no*

*Are you subject to specific allergies:*_____ *Date of last Tetanus Shot:* _____

Please write any specific condition which would affect participation: _____

If you have answered yes to any of the above, please specify and include any medications: _____

_____

In the event of sickness or accident, I will not hold the Plymouth Area Coalition for the Homeless responsible. In case of sickness or accident, I authorized the calling of my physician and give him/her permission to hospitalize, secure proper treatment for, and to order injection anesthesia for surgery to myself if I am rendered unable to give permission.

Signature: _____ *Date:* _____

Witness: _____ Date: _____

VOLUNTEER AGREEMENT

NAME: _____ *START DATE:*_____

PROGRAM: _____ *DAYS/HOURS:* _____

"I understand that the Plymouth Area Coalition for the Homeless relies on its volunteers for the smooth operation of the programs. As a volunteer for the agency I agree to"

1. *Arrive on time for my shift*
2. *Call in advance if I cannot arrive on time*
3. *Make a commitment for a specific amount of time I are available.*

I further agree to abide by the attached policies governing staff behavior in regard to drug and alcohol use, confidentiality, and conflict resolution as set down in the Coalition's Personnel Policies.

If I am hired to work with children in any of the Coalition's other programs, I agree to submit a request for CORI.

Signature: _____ *Date:* _____

DRUG-FREE WORKPLACE

The Plymouth Area Coalition for the Homeless, Pursuant to Drug Free Workplace Act of 1988, is committed to maintaining a workplace that is safe for all of its employees. Recognizing that the use and/or abuse of alcohol and other drugs creates unsafe and unhealthy conditions for everyone, it is the policy of the Coalition to prohibit the use of alcohol and other than prescription controlled substances during working hours.

The Coalition recognizes that addiction to or dependency on alcohol and other drugs is a treatable disease and that employees so affected should be provided with the opportunity to seek treatment. Therefore, any employee who either through supervisor referral or self identification, is believed to be abusing alcohol and/or other drugs will be asked to consult with a substance abuse professional regarding treatment. The choice of the substance abuse professional will be up to the employee who is referred to inpatient treatment and the employee will be expected to bear the entire cost, either personally or through their own health insurance coverage, for any and all aspects of their treatment. An employee who is referred to inpatient treatment may apply accrued sick leave and vacation time to the period of that inpatient treatment. In the event that such accrued time is insufficient, the employee will be granted an unpaid leave of absence for the balance of the inpatient treatment period.

An employee who has consulted a substance abuse professional and, as a result, has entered into a treatment program specified by said professional, will be required to show that they are following the treatment program established. The employer, the employee and the substance abuse professional will agree upon evidence of compliance with the treatment program. In the event that the treatment program is not followed or the employee does not provide that evidence of compliance, the employee will be subject to immediate dismissal.

CONFIDENTIALITY STATEMENT

I understand that the staff, volunteers, and residents of the Coalition's programs must adhere to strict confidentiality within the programs but the relevant information about the families will be shared as needed with other staff, and volunteers.

DISMISSAL POLICY

Reasons for dismissal may include, but are not limited to, the following:

Misconduct
Negligence
Serious breach of confidentiality
Acceptance of valuable consideration which was given with the expectation of influencing the volunteer in the performance of his/her duties
Falsification of records or use of position for personal advantage

CONFLICT RESOLUTION

When a conflict arises between myself and another resident, volunteer or staff person, I will first discuss the problem with them in a private setting and attempt to work it out, together. If there is a no resolution, I will ask a shelter staff person, not involved in the conflict, to meet with the parties to attempt to mediate an acceptable resolution. If no resolution can be made, I may file a formal grievance with the Grievance Board.

_____
Volunteer

_____
Witness

_____
Date

PLYMOUTH AREA COALITION FOR THE HOMELESS, INC.
149 BISHOPS HIGHWAY
KINGSTON MA 02364

XPLACH
EOHHS

CORI REQUEST FORM

The Plymouth Area Coalition for the Homeless has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant/employee for position of_____ _, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

_____
Applicant/Employee Signature

****

APPLICANT/EMPLOYEE INFORMATION (PLEASE PRINT)

_____
LAST NAME FIRST NAME MIDDLE NAME SUFFIX

_____
FORMER LAST NAME 1 LAST NAME 2 LAST NAME 3

_____ Last six SSN: _____ - _____
DATE OF BIRTH

_____ _____
GENDER RACE

_____
FATHER'S LAST NAME FIRST NAME

_____
MOTHER'S LAST NAME FIRST NAME MAIDEN NAME

FORMER ADDRESSES: _____

_____

HEIGHT: ____ft. ____in. WEIGHT: _____ EYE COLOR:_____

STATE DRIVER'S LICENSE NUMBER: _____

***THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION