



Your mental wellness.
Our mission.

Linkages to Learning
VOLUNTEER APPLICATION

Date of Application _____

Submit completed applications to:
Rameela Tuladhar, Volunteer Coordinator
volunteer@Every-Mind.org | Fax 301.738.1030

PERSONAL INFORMATION				
NAME		DATE OF BIRTH		AGE
ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS		
PREFERRED METHOD OF CONTACT (CHECK ONE): <input type="checkbox"/> E-MAIL <input type="checkbox"/> CELL PHONE <input type="checkbox"/> HOME PHONE				
PLACE OF EMPLOYMENT			OCCUPATION	
DOES YOUR EMPLOYER MATCH YOUR VOLUNTEER HOURS OR HAVE ANOTHER TYPE OF CORPORATE GIVING BENEFIT?			<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> UNSURE
EMERGENCY CONTACT/ RELATIONSHIP			PHONE	
DO YOU SPEAK A FOREIGN LANGUAGE?		IF YES, WHICH LANGUAGE(S)?		
<input type="checkbox"/> YES <input type="checkbox"/> NO				
HOW DID YOU HEAR ABOUT EVERYMIND?				
<input type="checkbox"/> CURRENT OR FORMER VOLUNTEER	<input type="checkbox"/> ONLINE SEARCH	<input type="checkbox"/> COMMUNITY FLYER		
<input type="checkbox"/> VOLUNTEERMATCH.ORG	<input type="checkbox"/> FAIR OR EVENT	<input type="checkbox"/> FRIEND		
<input type="checkbox"/> MONTGOMERY COUNTY VOLUNTEER CENTER	<input type="checkbox"/> NEWSPAPER	<input type="checkbox"/> OTHER		
<input type="checkbox"/> TWITTER	<input type="checkbox"/> FACEBOOK	<input type="checkbox"/> INSTAGRAM		
WOULD YOU LIKE TO RECEIVE E-MAIL UPDATES FROM EVERYMIND? <input type="checkbox"/> YES <input type="checkbox"/> NO				
EDUCATION				
<input type="checkbox"/> HIGH SCHOOL	YEAR	DID YOU GRADUATE?		
<input type="checkbox"/> UNDERGRADUATE	YEAR	MAJOR		
<input type="checkbox"/> GRADUATE	YEAR	MAJOR		
<input type="checkbox"/> OTHER	YEAR	CERTIFICATIONS/AWARDS		

SKILLS/ INTERESTS

Please list any current or past employment or volunteer experience.

COMPANY/ORGANIZATION	RESPONSIBILITIES/DUTIES	FROM	TO

Please list any special interests, hobbies, or areas of expertise?

REFERENCES

Please list the following information of three non-family references at least one from a professional contact, e.g., employer, teacher, clergy. *Do not list more than one personal friend.*

NAME	RELATIONSHIP
ADDRESS	CITY/STATE/ZIP
E-MAIL	TELEPHONE
NAME	RELATIONSHIP
ADDRESS	CITY/STATE/ZIP
E-MAIL	TELEPHONE
NAME	RELATIONSHIP
ADDRESS	CITY/STATE/ZIP
E-MAIL	TELEPHONE

Have you ever been convicted of a crime or denied bond? NO YES

Have you ever been convicted of an offense involving violence against a person or child including sexual offense?

NO YES

If yes, please explain.

Why do you want to volunteer with Linkages to Learning?

What kind of volunteer work would you like to do?

Are you applying for a Student Service Learning (SSL) experience? NO YES

Name of SSL Coordinator	Phone Number
Name of School Counselor	Phone Number

Please write in the times you are available on the following days.

Days	Mon	Tues	Wed	Thurs	Fri
Times					

If under 18 years of age:

I give my informed consent for my child to volunteer with the Linkages to Learning Program. I understand that my child is responsible for reporting SSL hours to his/her school administration and for keeping a log of their volunteer hours. I certify that I am the applicant's parent / legal guardian.

PRINTED NAME	SIGNATURE	DATE
PHONE NUMBER	EMAIL ADDRESS	

Criminal background investigations will be conducted for all new adult volunteers for positions that involve direct contact with children. Applicants must fill out the Applicant Release and Authorization form which permits Linkages to Learning to conduct a background check through National Background, Inc. This record will be kept in a confidential file for three (3) years from the date of application. Linkages to Learning is a collaborative initiative among the Montgomery County Department of Health and Human Services, Montgomery County Public Schools and private community providers. Linkages to Learning is a program of EveryMind and is the private community provider and partner at this Linkages to Learning Site.

I affirm, under penalties of perjury, that the contents of this application are true. I understand that any false information provided by me may result in the discharge and/or the rejection of my application.

PRINTED NAME	SIGNATURE	DATE
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I hereby authorize EveryMind or authorized representatives to obtain and release my information pertaining to my backgrounds, for volunteer purposes.

PRINTED NAME	SIGNATURE	DATE
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