BLINDNESS SUPPORT SERVICES, INC

VOLUNTEER APPLICATION

Date: _____

Name: _____Age: _____

Address: _____

_____

Phone #: _____Cell: _____

Emergency Contact:_____

(Name/Phone Number)

Approximate Start Date: _____

# of Hours Desired: _____

Time Available: _____

Areas of Experience: _____

_____

Physical Disabilities: _____

Language Spoken: _____

How did you hear about BSS? _____

_____

Why would you like to volunteer at BSS? _____

_____

Have you done volunteer work before? _____

If yes, what type and where? _____

Select a department you want to volunteer in.

___Office Assistant ___Orientation & Mobility

___Braille Department ___Travel Training

___Assistive Technology ___Independent Living Skills

___Children's Department ___Older Adults Department ___Other