# Volunteer Application

enable ability
working with disabled people

The information given in this form will be used in an emergency situation. Some of the information is used for monitoring & evaluation purposes but is kept strictly confidential. If you have any questions, or require assistance completing this form please contact us on 023 9267 1874 (office) or send an email to the Enable Ability Volunteer Officer (eavolunteers@enableability.org.uk). All information will be treated as confidential.

## CONTACT INFORMATION:

| NAME: | | M F | DATE OF BIRTH: | |
|---|---|---|---|---|
| ADDRESS: | | | | |
| | | | POST CODE: | |
| TELEPHONE NUMBER: | | | MOBILE NUMBER: | |
| EMAIL: | | | | |
| EMERGENCY CONTACT: | | | EMERGENCY CONTACT NO: | |

## GENERAL INFORMATION:

Do you have a full UK driving licence? ☒ YES ☒ NO

If YES would you be prepared to drive to activities? ☒ YES ☒ NO

Do you have a current First Aid certificate? ☒ YES ☒ NO EXP DATE:

Why do you want to be a volunteer with Enable Ability?

If known, which project would you be interested in volunteering with? ☒ Junior Club (ages 5-12) ☒ Wheelchair Basketball ☒ Teenage or Youth Projects

Do you have any relevant experience of working with children/young people with disabilities?

Do you have any relevant skills or qualifications relevant to working with children/young people?

How did you first hear about Enable Ability?

Please turn over…

## MEDICAL INFORMATION:

Do you suffer from any of the following: Yes / No

☒ Asthma ☒ Epilepsy ☒ Diabetes ☒ Heart Problems

Please give details of any conditions indicated above or any other condition you may be affected by?

Please give details of any treatment or medication you may require during an activity? eg. Inhaler

Do you have any allergies? Please give details

| NAME OF DOCTOR: | | TELEPHONE NO: | |
|---|---|---|---|
| ADDRESS: | | | |
| | | POST CODE: | |

## REFERENCES:

Please give the **names, addresses and email addresses of two referees, and their contact number if known**. One of these references must have known you for at least 2 years.

Please do not use family members as references.

**REFERENCE A:**

**REFERENCE B:**

Enable Ability will contact both references once your application has been received

## CONSENT:

Please tick the statements that you are consenting to:

☐ I give permission to attend activities through Enable Ability

☐ I give permission to be given emergency medical treatment in my absence should it be required

☐ I give permission to appear in Enable Ability publicity (inc. Local / National Press, & the EA website)

| SIGNATURE: | | NAME: | | DATE: | |
|---|---|---|---|---|---|

**Please return this form to: Volunteer Officer, Enable Ability, 311-313 Copnor Road, Portsmouth PO3 5EG**

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Details entered on this form will be stored electronically in accordance with the EU GDPR of 2018