

## Violence Intervention Project Volunteer Program Application

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers:

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Other: \_\_\_\_\_

Email Address:

\_\_\_\_\_

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Please explain why you are interested in volunteering at VIP.

What are your areas of interest and abilities which may be useful in your work with VIP?

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What is your definition of a battered woman?

I am willing to assist VIP, on a volunteer basis, in the following areas (list is not exhaustive):

Transportation \_\_\_\_\_ Office Tasks \_\_\_\_\_ Childcare \_\_\_\_\_

Cleaning/Maintenance \_\_\_\_\_ Other (specify) \_\_\_\_\_

*(There is potential to do a variety of other volunteer tasks after being with VIP for a while and demonstrating your capabilities.)*

Thank you in your interest in Violence Intervention Project. By signing below, you verify that you have completed this application to the best of your ability and give VIP permission to contact those people listed below as references:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant References (include complete address)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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Forms to complete:

Informed Consent for a Background Check: \_\_\_\_\_

Findings:

Cleared for Volunteering: \_\_\_\_\_

Not cleared for volunteering: \_\_\_\_\_

Volunteer Confidentiality Policy

Confidentiality is essential in order to maintain a safe environment in this agency.

1. Volunteers must not share the names of other people they may see when coming to VIP for groups, supervised visitation or exchanges, or any other services.
2. Violation of this policy may result in immediate termination of your services.

I have read this Confidentiality Policy and will abide by its contents.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Non-Profit Informed Consent  
Violence Intervention Project  
PO Box 96  
Thief River Falls, MN 56701**

Date: \_\_\_\_\_

The following named individual has made application with this agency for:

- Employment
- Volunteering
- Board of Directors

Last name of applicant (please print)

\_\_\_\_\_

First name (please print)

\_\_\_\_\_

Full middle name (please print)

\_\_\_\_\_

Maiden, Alias, of Former Names

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Sex

Male

Female

Social Security Number (optional)

\_\_\_\_\_

I authorize the Minnesota Bureau of Criminal Apprehension to disclose all criminal history record information to Violence Intervention Project for the purpose of (check box) with this agency.

- Employment
- Volunteering
- Board of Directors

The expiration of this authorization shall be one year from the date of my signature.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date