

**Capital Region Mental Health & Addictions**

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| **Volunteer Application** | |
| **Contact Information** | |
| Name | D.O.B. |
| Phone | |
| Address | |
| Email | |
| Preferred method of contact | |
| **Volunteer Information** | |
| Why would you like to volunteer for the Association? | |
| Areas of Interest/Experience | |
| Depending on the volunteer opportunity, you may be asked to complete a criminal record check. Are you happy to do that? Yes No | |
| Is there any additional information you would like to share? | |
| Signature: Date: | |