**Volunteer Application**

|  |
| --- |
| **Role Applied For** |
| Position |  |
| Region |  |

|  |
| --- |
| **Your Details** |
| Title |   | First Name  |   | Surname |  |
| Address |   |
| City / Town |   |
| Post Code |   | Telephone |   |
| Email |   |

|  |
| --- |
| **Person to contact in case of emergency** |
| Title |   | First Name  |   | Surname |  |
| Address |   |
| City / Town |   |
| Post Code |   | Telephone |   |
| Email |  |

**References**

Please give details of two people (who are not related to you) who can comment on your suitability as a volunteer. Painting in Hospitals reserves the right to contact all previous organisations’ where you have worked in a paid or unpaid capacity.

|  |
| --- |
| **Referee 1** |
| Title |   | First Name  |   | Surname |  |
| Address |   |
| City / Town |   |
| Post Code |   | Telephone |   |
| Email |  |

|  |
| --- |
| **Referee 2** |
| Title |   | First Name  |   | Surname |  |
| Address |   |
| City / Town |   |
| Post Code |   | Telephone |   |
| Email |  |
| **What skills and experience will you bring?** |
|  |

|  |
| --- |
| **Why would you like to join Paintings in Hospitals as a volunteer?****What tasks interest you most?***Please refer to the role profile document you were sent or the volunteering section on our website if applicable* |
|  |

|  |
| --- |
| **How long do you plan to volunteer for and what are your plans for the future?***Please indicate how much time you can offer us, how frequently, and which days of the week/month suit you best* |
|  |

|  |
| --- |
| **Have you ever worked as a volunteer before? If yes, please give details** |
|  |

|  |
| --- |
| **Tell us about your hobbies and interests** |
|  |

**Availability**

*Please leave the applicable availability, deleting the other options as appropriate:*

In full-time employment | In part-time employment | In part-time employmentNot working / retired from employment Not working / retired from employment

I In full-time further education / school

**Health**

*Are there any restricting factors or medication that we should be aware of? Please* *delete as appropriate:*

Yes | No

|  |
| --- |
| **If yes, please specify how we can help you** |
|  |

|  |
| --- |
| **Please tell us how you heard about Paintings in Hospitals** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |   | **Date** |   |

Please return your completed form to:  mc@paintingsinhospitals.org.uk

**Paintings in Hospitals** Unit 11, Earlsfield Business Centre, 9 Lydden Road, London, SW18 4LT