



Volunteer Application

Section I. General Information

Date: _____ Date of Birth: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____

Phone: _____ Email: _____

Name of School: _____

How did you hear about our program? _____

Section II. Dates and Times Requested

Start Date: _____

Total Hours Needed: _____

Days of Week and Time Available (minimum 2 hour shift): _____

Section III. Confidential Information

I agree to maintain complete confidentiality in all that pertains to the condition and/or affairs of any patient under the care of PT@acac. I realize that I am obligated to refrain from discussing any patient or information regarding a patient with any person except my supervising physical therapist. I have been advised against and accept any responsibility for any breach on my part respecting confidential information.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Section IV. Volunteer Agreement and Certification of Information

I agree, as a volunteer of PT@acac:

1. To maintain confidentiality of all information that I obtain directly or indirectly concerning patients, families or personnel.
2. I am applying for an unpaid, volunteer position and not paid employment, I understand that neither this volunteer application nor the acceptance or performance of a volunteer position constitutes a guarantee or promise of future employment.
3. To follow the Volunteer Guidelines of PT@acac.
4. To wear the designated uniform at all times

Applicant Signature: _____ **Date:** _____

Section V. Parental Consent

The information in this application is correct. I am aware of the various tasks that my child will be required to perform. My child has my permission to serve as a volunteer at PT@acac.

Signature of Parent/Guardian: _____ **Date:** _____

Section VI. Photo Release

The undersigned hereby releases any photos, video or likenesses of the participant named in this form taken by PT@acac, to be used for promotional and publication materials. PT@acac does not attach names to photos without permission.

By signing below, I am indicating that I have read the provisions of this form, understand them, and agree to them.

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

email: stephenj@acacpt.com

fax: 434-465-6834

Address: Stephen Jackson, 504 Albemarle Square, Charlottesville, VA 22901