



Mental Health Association of Franklin and Fulton Counties

A Peer Run Organization

Volunteer Application

Please Print Clearly

_____ Date

_____ Legal Name

_____ Preferred Name

_____ Address

_____ City

_____ State

_____ Zip

_____ Phone Number

_____ E-mail Address

EDUCATION/TRAINING

High School: 9 10 11 12 Diploma/GED: Yes No	Veteran: Yes No
College: 1 2 3 4 Degree: _____	Military Certifications: _____ _____ _____
Other Training: _____ _____ _____	
_____ _____	

Areas of Interest for Volunteering:

- | | |
|---|---|
| <input type="checkbox"/> Community Support Program
(Helpline, Senior Reach, Meetings/events) | <input type="checkbox"/> Administrative Assistant |
| <input type="checkbox"/> Individual/Family Satisfaction Team | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Event Planning | <input type="checkbox"/> Other: _____ |

Are you planning to volunteer as part of a school program/requirement? Yes No
 If yes, please list the individual/advisor to communicate with and phone number:

Are you planning to volunteer as part of community service requirements? Yes No
 If yes, please list the individual in charge of your community service and phone number:



Mental Health Association of Franklin County Inc.

A Peer Run Organization

Do you possess a current drivers license? Yes No

WORK EXPERIENCE

Dates Worked	Employer	Position	Reason for Leaving
to			
to			
to			

REFERENCES

Name	E-Mail Address	Phone

Anything else you would like to share:

I certify that the information provided in this application is accurate to the best of my ability and I understand that any information found to be falsified could be grounds for termination:

Signature of Candidate

Date: