



# VOLUNTEER APPLICATION & AGREEMENT

ARLINGTON BUSINESS PARTNERSHIP

9800 Indiana Ave STE 2, RIVERSIDE, CA 92503 • 951-509-1100

[WWW.RIVERSIDEABP.COM](http://WWW.RIVERSIDEABP.COM) | [INFO@RIVERSIDEABP.COM](mailto:INFO@RIVERSIDEABP.COM)

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ORGANIZATION/SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_ SHIRT SIZE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

EVENT/PROGRAM/PROJECT: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ MEDICAL INSURANCE PROVIDER: \_\_\_\_\_

## PLEASE SELECT ONE SHIFT

| <input type="checkbox"/> ALL DAY | <input type="checkbox"/> SHIFT 1 | <input type="checkbox"/> SHIFT 2 | <input type="checkbox"/> SHIFT 3 |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| 6:00 a.m. – 7:00 p.m.            | 6:00 a.m. – 11:00 a.m.           | 10:00 a.m. – 3:00 p.m.           | 2:00 p.m. – 7:00 p.m.            |

## VOLUNTEER AGREEMENT & MEDIA RELEASE

I choose to participate with the ABP as a volunteer and understand that my services are donated to the ABP without contemplation of compensation or future employment, and given for humanitarian, religious or charitable reasons. I understand that I am covered under the ABP liability insurance in the event of an injury from rendering a volunteer service. I will report any injury or incident to my supervisor immediately. I agree to abide by any rules and directions provided by those helping the ABP. I further authorize the ABP to capture photos and/or video of myself for use in ABP marketing materials.

PARTICIPANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## PARENT/GUARDIAN MEDIA RELEASE & CONSENT FOR MEDICAL, DENTAL, HOSPITAL CARE OF MINOR VOLUNTEERS AGES 17 & UNDER MUST HAVE A PARENT OR LEGAL GUARDIAN CONSENT

I, the parent or legal guardian of the minor listed above, chooses to permit him/her to participate with the ABP as a volunteer. I understand that my child's or ward's services are being offered on a voluntary basis without anticipation of any financial remuneration. I agree that he/she will abide by any rules and direction provided by those helping the ABP. I understand that my child is covered under the ABP liability insurance in the event of an injury from rendering volunteer service. He/She will report any injury or incident to his/her supervisor immediately. I, the parent or legal guardian of the minor listed above, authorize medical, dental, and surgical or hospital care, treatment, or diagnosis of said minor and I agree to pay for any medical, dental, surgical, or hospital diagnosis, treatment, or care rendered to or for said minor for non-industrial injuries. I, the parent or legal guardian of the minor listed above, authorize the ABP to capture photos and/or videos of the above minor child, or ward, for use in ABP marketing materials.

PARTICIPANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_