VOLUNTEER APPLICATION & AGREEMENT

ARLINGTON BUSINESS PARTNERSHIP
P.O. BOX 7338, RIVERSIDE, CA 92513 ● 951-509-1100 ● FAX: 951-509-6802
WWW.RIVERSIDEABP.COM | 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

☐ ALL DAY	☐ SHIFT 1	☐ SHIFT 2	☐ 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: _____