



# AFRICANS IN PARTNERSHIP AGAINST AIDS (APAA)

## VOLUNTEER APPLICATION FORM

### A – CONTACT INFORMATION:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

E-Mail \_\_\_\_\_

Date of Birth (Optional) \_\_\_\_\_ Home Phone \_\_\_\_\_

Gender \_\_\_\_\_ Work Phone \_\_\_\_\_

Languages spoken:  English  French  Other: \_\_\_\_\_

Languages written:  English  French  Other: \_\_\_\_\_

### Emergency Contact Name & Health Information:

Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Do you have any health concerns we should know about?

### B – SKILLS PROFILE:

Occupation \_\_\_\_\_ Employer (Optional) \_\_\_\_\_

Educational Institution (Optional) \_\_\_\_\_

What Skills would you like to use in a volunteer role with us?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Counseling              | <input type="checkbox"/> Graphic Design     | <input type="checkbox"/> Fundraising                     |
| <input type="checkbox"/> Community Outreach      | <input type="checkbox"/> Computer Networks  | <input type="checkbox"/> Event Planning                  |
| <input type="checkbox"/> Workshop Facilitator    | <input type="checkbox"/> Word Processing    | <input type="checkbox"/> Special Events Promotion        |
| <input type="checkbox"/> Committee Participation | <input type="checkbox"/> Desktop Publishing | <input type="checkbox"/> Translation/Interpreter Service |
| <input type="checkbox"/> Food Services           | <input type="checkbox"/> Childcare          | <input type="checkbox"/> Other: _____                    |

### C – VOLUNTEER OPPORTUNITIES:

Please check your area(s) of interest. Indicate your preference by ordering them #1, 2, 3, etc.

#### Community Outreach

- Leadership/community Dev
- Awareness/prevention education
- Presentations/displays
- Advocacy Support
- Kibaru Newsletter

#### Support Services programs

- Leadership/Karibu
- Peer Support
- Practical Support
- Translation/Interpretation
- Speakers' Bureau
- Support Group Facilitator

#### Fundraising

- Leadership/Committee work
- Special Events

#### Office Help

- Reception
- Data Entry
- Clerical

Other: \_\_\_\_\_

Please turnover ➡

**D – AVAILABILITY:**

Please mark below (√) the days/times you are available to volunteer

Time of Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

**E – Knowledge about APAA and experience with HIV/AIDS**

How did you learn about volunteering with Africans in Partnership Against AIDS?

- From Newspaper, Magazine, Television     Health Care Provider     Telephone Book
- Referral from another Agency     APAA Pamphlets     Word of Mouth
- Volunteer/employment centre     Internet

Please describe in your own words any personal or professional (including volunteer) experience you may have with HIV/AIDS:

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Please describe why you would like to volunteer at APAA:

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**F – REFERENCES:**

Please provide the names of two personal or professional references:

- 1. Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_
- 2. Name: \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**G – VOLUNTEER CONFIDENTIALITY AGREEMENT:**

At all times, the privacy and dignity of clients, donors, volunteers and staff will be respected, and the mission, vision and philosophy of the APAA will be followed in accordance with the APAA’s policies, standards and guidelines. As a volunteer of the Africans in Partnership Against AIDS, you may have access to information and documents relating to clients, donors, volunteers and staff that are private and confidential in nature. All volunteer and client records are the property of the APAA and will be treated as confidential material; reasonable care and caution should be exercised to protect and maintain total confidentiality. No person shall read records or discuss such information unless there is legitimate purpose. Volunteer and Client interactions shall not be discussed with people outside the APAA, including immediate family members, throughout and beyond tenure with the APAA.

**By signing below, you acknowledge that the information provided is true and accurate, and that you have read, understand, and will abide by the agreement above. And, by signing below, you grant the Africans in Partnership Against AIDS permission to contact the references listed.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parents/Guardian (if under 18years old): \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN BY MAIL, FAX OR EMAIL TO:**

Africans in Partnership Against AIDS  
314 Jarvis Street, Suite 101  
Toronto, ON M5B 2C5  
Fax: 416-924-6575  
Email [Volunteers@apaa.ca](mailto:Volunteers@apaa.ca)

**Thank you for completing this application form.**