DSYTC Volunteer Application

Your Contact Information

Date:

Title:	First Name:	Last Name:
Street Address:		
City:	Province:	Postal Code:
Home Phone:		
Work Phone:		
E-Mail Address:		
Emergency Contact Name:	Emergency Contact Number:	
Have you volunteered with DSYTC before? □Yes □No	If yes, when:	
How did you hear about DSYTC?		

Your Availability

I can commit to:

□ Event Only □Occasional □Once a week □More than Once a week □ # of hours/week_____

I can start on: _____ and am available until _____

Do you have a preference of volunteering at □ Carp Campus □ Carleton Place Campus □Either □Both

Shift Times (Can be flexible depending on position)	**1st Day of the Week I am Available**	**2nd Day of the Week I am Available**
9:00 am- 12 pm Weekdays (Academic support)		
3 pm- 5 pm Weekdays (Prosocial activity leaders)		
3:30pm -5:30pm Weekends (Prosocial activity leaders)		

- I'm applying to this specific volunteer position:_____

	Description of Volunteer Tasks
Academic Support	• Provide personal attention to help keep DSYTC clients focused, engaged and motivated • Support clients as they work towards completion of Ontario High School credits • Teach and adapt to the client's learning curve • Communicate and Coordinate with the campus teacher

Prosocial Activity Leader	• To share knowledge and experience in activities which can enhance the lives of DSYTC clients and enrich the treatment experience such as arts and crafts, music, dance, drama

Your Interests

I am interested in volunteering for the DSYTC because:

_____
_____
_____
_____

I could share the following talents, qualifications or skills to DSYTC youth:

_____
_____
_____
_____

My other interests/hobbies:

_____
_____
_____
_____

Please Let Us Know:

Do you have any medical conditions that DSYTC should know about? (i.e. Allergies, medications, physical ailments etc.):

Are you related to a Staff Member, Client, or other Volunteer at the DSYTC? If yes, please list their name(s) below:

My other interests/hobbies:

Agreement and Signature

By submitting this application, I understand that:

Volunteer placement is made on the basis of the program requirements, the skills and experience of the applicant and, when appropriate, successful reference checks. Dave Smith Youth Treatment Centre may need to collect personal information appropriate to the position(s) applied for concerning my background and employment/volunteering history, and to conduct reference checks.

By signing your name below, you acknowledge that the information provided is true and accurate and that you have read and understand the points above.

Name (printed)	
Signature	
Date	

THANK YOU FOR COMPLETING THIS FORM

Please submit completed application and, if you wish, a copy of your resume to:

EMAIL	MAIL	FAX
volunteer@davesmithcentre.org **PHONE** 613-594-8333 ext. 1204	**Dave Smith Youth Treatment Centre** **786 Bronson Avenue** **Ottawa, ON** **K1S 4G4**	(613) 594-5623 Attn: Volunteer Program