

VOLUNTEER REGISTRATION FORM (2021 / 2022)

SOBC Local:** **COMOX VALLEY** Returning Volunteer New Volunteer

**Local is the community you wish to volunteer with

VOLUNTEER INFORMATION		
First Name:	Last Name:	
Date of Birth (mm/dd/yyyy):	Gender:	
Email:		
Street Address:		City:
Postal Code:	Home Phone:	Cell Phone:
NCCP# (if known):		
VOLUNTEER POSITIONS (please check the roles you are interested in)		
Sport Programs		
<input type="checkbox"/> 5-Pin Bowling <input type="checkbox"/> Bocce <input type="checkbox"/> Cross Country Skiing <input type="checkbox"/> Curling	<input type="checkbox"/> Floor Hockey <input type="checkbox"/> Golf <input type="checkbox"/> Powerlifting <input type="checkbox"/> Rhythmic Gymnastics <input type="checkbox"/> Softball	<input type="checkbox"/> Swimming <input type="checkbox"/> Track & Field <input type="checkbox"/> FUNdamentals (ages 5-12)
I'm interested in role of <input type="checkbox"/> Head Coach <input type="checkbox"/> Assistant Coach <input type="checkbox"/> Program Volunteer		
Administration Roles		
Executive <input type="checkbox"/> Local Coordinator <input type="checkbox"/> Treasurer <input type="checkbox"/> Program Coordinator <input type="checkbox"/> Volunteer Coordinator	<input type="checkbox"/> Fundraising Coordinator <input type="checkbox"/> Public Relations Coordinator <input type="checkbox"/> Registration Coordinator <input type="checkbox"/> Secretary	Other Roles <input type="checkbox"/> General Volunteer <input type="checkbox"/> Event Volunteer <input type="checkbox"/> Other
Additional comments on the volunteer roles you are interested in (optional)		
REFERENCES – Please provide two references (only required for NEW volunteers)		
Name:	Phone:	Email:
Relationship to volunteer applicant:		
Name:	Phone:	Email:
Relationship to volunteer applicant:		

Volunteer Name: _____ SOBC LOCAL: COMOX VALLEY

PARENT / GUARDIAN INFORMATION (only required if volunteer is under 19)

Name: _____ Relationship to Volunteer: _____

Same Contact Info as Volunteer (please list anything different below)

Street Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Cell Phone: _____

Email: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____

Relationship to Volunteer: Parent/Guardian Spouse Friend Relative

Home Phone: _____ Cell Phone: _____

MEDICAL INFORMATION

Health Card #: _____

Physician Name: _____ Physician Phone: _____

Seizures: Yes No If yes, please indicate seizure type, frequency, and treatment plan:

Allergies: Yes No If yes, please provide Allergy Detail (including food, drugs, or other)

Allergy Treatment (ie. does the volunteer carry an epi-pen, medication, etc.):

Medical Notes (please include additional information as applicable)

By filling in my name below I acknowledge that the information provided on this form is correct to the best of my knowledge and I will update this information should it change

VOLUNTEER SIGNATURE (if 19 years or over)

Volunteer Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for volunteer who is under 19)

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

****If filling in, and submitting the form online you may type your name in the signature line****