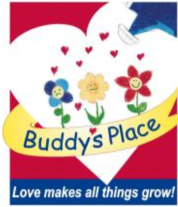

Pillars Community Health
Healing. Caring. Educating.

Buddy's Place

A Program for Bereaved Children and Their Families

VOLUNTEER APPLICATION FORM

Please Print DATE ______________

NAME ____ PRONOUNS: ____________
(last) (first)

ADDRESS ____ __________________
(street) (city) (zip)

PHONE/CONTACT ____
(cell) (home/other) (E-mail)

How did you learn about Buddy's Place?

____

____

Why do you want to volunteer at Buddy's Place?

____

____

____

Please list any volunteer experience you have, especially with children and support groups.

____

____

____

____

In which of the following areas would you be willing to help?

- ❐ Group Facilitator
- ❐ Greeter
- ❐ Office/Clerical
- ❐ Babysitting
- ❐ Special Events

Are you fluent in any languages other than English? If so, which language(s)?

____

____

Are you currently a member of a support group for grieving persons? ❒ yes ❒ no
If yes, what is the name of the group?

____

Have you ever participated in a support group for grieving persons? ❒ yes ❒ no
If yes, when were you a participant and what was the name of the group?

____

____

Have you experienced the death of a family member or close friend? ❒ yes ❒ no
If yes, please comment on your experience.

____

____

____

Are you able to volunteer on Monday or Tuesday evenings from 5-8pm?

- *Monday: ❒ yes ❒ no*
- *Tuesday: ❒ yes ❒ no*

Are you able/willing to facilitate in the following manner:

- *In Person: ❒ yes ❒ no*
- *Virtual Platform (Zoom): ❒ yes ❒ no*

Are you able to commit to one year of volunteering to Buddy's Place? ❒ yes ❒ no

If Applicable:

PLACE OF EMPLOYMENT ____

JOB DESCRIPTION ____

ARE YOU A STUDENT? ❒ no ❒ yes WHAT SCHOOL DO YOU ATTEND? ______________________

WHAT IS YOUR AREA OF STUDY? ____

I understand I will be required to submit my vaccination status. I will also have a background check and fingerprinting done at a location specified and paid for by Pillars Community Health: ❒ yes ❒ no

YOUR SIGNATURE ___________________________________ DATE ______________

PLEASE RETURN THIS COMPLETED FORM VIA EMAIL TO :

MHALM@PCHCARES.ORG

BUDDY'S PLACE, A PROGRAM OF PILLARS COMMUNITY HEALTH
708.995.3751

FOR OFFICE USE ONLY:
Date application rec'd ___________ General Application_____________________ Date training completed ___________
Comments ____