PARENT-CHILD
RELATIONSHIP ASSOCIATION

PCR Volunteer Application

Please fill out the application and return it to the Volunteer Program by e-mail or mail. Please note all PCR volunteers must be at least 14 years old. For more information, please submit your questions to volunteer.pcrnyc@gmail.com **or call 718-210-3743.**

Name: _____ **Date of Birth**: ____ / ____ /_____
First Middle Last

Gender (what do you classify yourself as**):** _____ **Pronoun(s)**: _____

Address: _____
Number, Apt #, and Street City State Zip Code

Phone: _____ **E-mail**: _____

School: _____

Why do you wish to volunteer at PCR? What do you hope to gain from this volunteer experience?

_____

_____

_____

What language(s) do you speak fluently? __ English __Chinese (Cantonese) __ Chinese (Mandarin) __ Chinese (Fujianese) __ Spanish __ Other(s)_____

What type of skills do you have? *(Software, artistic skills, etc...)* _____

_____

Have you applied for volunteer work at PCR in the past? _____

Have you ever been affiliated with PCR? If so, please indicate your relationship (family of staff, program participant, volunteer, etc...) _____

Previous Work/Volunteer Experience: *Attach additional pages if necessary.*

_____

_____

Educational Level: Please list your most recent educational background.

Name of School & Location (City, State)	Major	Last Grade Completed	Degree (if any)

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Emergency Contacts

Name	Address	Phone / Email	Relation

How did you hear about us? _____

Certification

I certify that the information provided on this application is true and accurate. I understand that the withholding of any information sought by this application, or the giving of false information may result in my disqualification from consideration for volunteer services for PCR or, if discovered after I have begun volunteering at PCR, my termination as a volunteer at PCR.

I certify that I have read the **PCR Volunteer Code of Conduct.** I understand that if I am offered and accept a volunteer position with PCR, I am responsible for abiding by the PCR Volunteer Code of Conduct. I understand that failure to abide by the aforementioned standards is grounds for immediate dismissal without compensation.

I HAVE READ THE ABOVE PRIOR TO SIGNING THIS APPLICATION.

Applicant Signature: _____**Date**: _____

Parent or Guardian
Signature required if under 18
Parent/Guardian Signature: _____ **Date**: _____

PARENT-CHILD
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PCR Medical Release Form

Name: _____ Date of Birth: ____ / ____ /_____

First Middle Last

Gender (what do you classify yourself as**): _____ Pronoun(s)**: _____

Address: _____

Number, Apt #, and Street City State Zip Code

Phone: _____

Insurance Carrier: _____Policy Number: _____

Blood Type: _____ Allergies: _____

Current Medication: _____

In case of an emergency, please contact:

Name: _____ Relation: _____Phone Number: _____

This authorization is intended to give Parent-Child Relationship Association (PCR) the right to give consent to not only authorization for emergency diagnostic procedures, medical, dental, surgical care and hospitalization, but for any diagnostic, medical, dental, surgical care and hospitalization that the person so designated deems advisable, and which the physician, dentist, or hospitalization personnel in said person's judgement may deem advisable.

It is intended that this document be presented to the physician, dentist, or appropriate hospital or medical representative at such time as the medical, dental, surgical care, or hospitalization shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that PCR shall act in my stead in making such decisions.

_____ _____ _____

Volunteer Name (Print) Signature Date

If under 18 years old,

_____ _____ _____

Parent/Guardian Name (Print) Signature Date