Chester Hill Neighbourhood Centre Inc.

Volunteer Registration Form

Title (Mr, Mrs etc): ____________________ **DOB:** _________________________

First Name: _______________________ **Last Name:**___________________________

Address:_____________________________ **Suburb**_________ **Post Code:**_________

Home Phone:_____________________ **Mobile:**____________________________

Email: ____

Languages you speak:____

How many hours per week can you volunteer (1 hour to 15 hours) ____________

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Relationship to client (son, daughter, neighbour etc)	
Full Name:	
Address:	
Suburb:	Post code:
Home phone:	Mobile:
Comments	

EMERGENCY CONTACT ***(or as above)***	
Relationship to client (son, daughter, neighbour etc)	
Full Name:	
Address:	
Suburb:	Post code:
Home phone:	Mobile:
Comments	

MEDICAL CONTACT	
Doctors Name:	
Address:	
Suburb:	Post code:
Home phone:	Mobile:
Medicare Number:	Medicare Expiry Date:
Allergies/ Medications	

Any medical conditions etc or other additional information we need to know about

I hereby give permission for Chester Hill neighbourhood Centre Inc to contact any of the above people if I am involved in an emergency situation.

Volunteer Print Name: ……………………………………………………...………

Volunteers Signature ………………………………………….. Date ……………

CHNC Representative Print Name …………………………………………………..