BREVARD
ASSOCIATION FOR
THE ADVANCEMENT
OF THE BLIND

**Volunteer Preliminary Information**

NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

IN CASE OF EMERGENCY:

CONTACT: _____ PHONE #: _____

RELATIONSHIP: _____

ADDITIONAL EMERGENCY INFORMATION: (M.D.; FAMILY; OTHER)

_____

1. WHICH PROJECT WOULD YOU LIKE TO VOLUNTEER ON? (check one)

   ☐ Independent Living ☐ Recording

   ☐ Other _____

2. Which days are you available to volunteer?

   ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

3. Do you have any experience working with the visually impaired or blind? (If yes, we will follow up with on our initial phone call)

   ☐ Yes ☐ No

4. Do you have any experience working in a recording studio or with voice production? (If yes, we will follow up with on our initial phone call)

   ☐ Yes ☐ No