



MARY BRIDGE
CHILDREN'S HOSPITAL
PART OF THE ELUNA NETWORK



Bridges Center for
Grieving Children

CAMP ERIN® VOLUNTEER APPLICATION

June 7, 8, and 9, 2024

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____
HOME WORK CELL

Birthday: _____ Ethnicity (optional): _____
MONTH / DAY / YEAR

Military Affiliation: Y N Branch: _____ E-mail: _____

Employer: _____

How did you hear about Bridges or **CAMP ERIN** volunteer opportunities?

Are you a member of the YMCA? Yes No Dietary restrictions (vegetarian, food allergies)?

T-Shirt size: Adult: XS S M L XL XXL 3X

Do you speak any foreign languages? Yes No Please specify:

What is your interest? (Check all that apply) Write down your First (1) and Second (2) choice.

Training is mandatory and will be provided by Bridges.

- | | | | |
|---|---------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Big Buddy | <input type="checkbox"/> Games | <input type="checkbox"/> Registration/Welcoming | <input type="checkbox"/> Arts/Craft |
| <input type="checkbox"/> Music | <input type="checkbox"/> Ritual | <input type="checkbox"/> Fundraising or Donation | <input type="checkbox"/> Photography |
| <input type="checkbox"/> Remembrance Walk | <input type="checkbox"/> Snacks | | |

Have any personal or work experience involving the following? (Please check)

- Camp Terminal illness Death of a loved one Bereavement work

If yes, please explain circumstances briefly here or in a separate letter and give the date(s)

For information:

Lisa Duke, MSW • 253-403-1966 • lisa.duke@multicare.org
PO Box 5299, Tacoma WA 98415-0299 • MS: 11125-BRID

Although we aim to place every volunteer, we reserve the right to determine volunteer appropriateness for service.

Why do you wish to volunteer with CAMP ERIN?

References: Supply three references with **complete addresses** which can include an employer or a relative not living with you. If you and a friend will be applying, you may not recommend each other.

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

A criminal background check is conducted on all staff and volunteers.

Who may we contact in case of emergency?

NAME	ADDRESS	CITY	STATE	ZIP
RELATIONSHIP				TELEPHONE(S)

This section is optional:

Do you have any health conditions/special needs which should be taken into consideration in making an assignment?

(Example: climbing stairs) _____

Do you have any experience, educational background or training which may be helpful to you as one of our camp volunteers? Explain and give dates. You may attach a sheet if you need more space.

I certify that the information supplied is true and complete to the best of my knowledge. Furthermore, I agree to all background checks required by this agency.

SIGNATURE OF APPLICANT

DATE

Mary Bridge Children's Hospital complies with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975 as amended, and Section 504 of the Rehabilitation Act. Mary Bridge Children's Hospital does not discriminate with regard to race, color, religion, creed, national origin, age, sex, marital status or the presence of any sensory, mental or physical handicap, or ability to pay.