

VOLUNTEER APPLICATION



Name _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Email Address _____

Date available to start volunteering. _____

Why do you want to volunteer at the museum? _____

Which volunteer opportunities would you be interested in?

- | | | |
|---|---------------------|-------------------|
| Museum Outreach | Info Desk Attendant | Docent |
| First Friday | Second Saturday | Office / Clerical |
| Special Events, 4:45 pm – 9:45 pm- Tuesday through Saturday, Sunday between 9:00 am and 9:00 pm | | |

What days are you available? HISAM is open Tuesday – Saturday 10 am – 4 pm.

Tue	Wed	Thu	Fri	Sat
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When are you available?

Mornings	Afternoons	Evenings
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Please indicate any special skill you have:

- | | | | |
|------------------|-----------|-------------|-------------|
| Computer | Education | Events | Languages |
| Customer Service | Office | Exhibitions | Other _____ |

Do you have volunteer Experience? Yes No

Do you have experience in the arts or in a museum? Yes No

If "yes" please describe: _____

Please return to:
 SFCA, Visitor Services
 250 S. Hotel St. 2nd Fl.
 Honolulu, HI 96813

Tel: (808) 586-9959
 Fax: (808) 586-0308

hisamvolunteers@gmail.com

Please list your current or previous employment / volunteer work.

Company / Organization _____

Company Organization _____

Dates volunteered or worked _____

Dates volunteered or worked _____

Duties _____

Duties _____

Supervisor/contact info _____

Supervisor / contact info. _____

Continue on reverse side if necessary

I certify that the above statements are true, and if found to be incorrect, I agree to resign immediately upon request without protest. I authorize the Hawai'i State Art Museum to verify these statements and references, and I authorize my former supervisors to furnish any relevant information. If a position may not be available at this time, I release the Museum from any liability of failure to notify me of future availability.

Applicant's Signature _____ Date _____

Emergency Contact Information

The purpose of this form is to enable the SFCA to make emergency contact on your behalf in the event that you would not be able to do so yourself. The information contained herein is strictly confidential and will not be used for any other purpose. Thank you for your participation.

Date: _____

Volunteer: _____

Please list any medical restrictions, requirements, allergies that you may have:

In case of emergency- notify:

Name: _____ **Relationship:** _____

Phone: _____

Address: _____

Physician: _____

Phone: _____