

**Application Form**

**You must be 18 years of age or older to apply, unless given special exception.  
Only those candidates selected for an interview will be contacted personally.**

**PERSONAL INFORMATION**

Full Name: \_\_\_\_\_ Title: (Mr./Mrs./Miss/Ms)  
(exactly as it appears on your passport)

Preferred Name: \_\_\_\_\_  
(if different from above)

Current Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

E-Mail: Fax: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Where and when did you learn about Bridges Of Hope:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am over 18 yrs of age: Y \_\_\_ N \_\_\_ Date of Birth  
(optional): \_\_\_\_\_

Gender: (required for accommodation) M \_\_\_ F \_\_\_

Does your passport allow you to travel to the countries for which you are applying to  
volunteer? Yes \_\_\_ No \_\_\_

Citizenship(s): \_\_\_\_\_

If you are traveling with others (friends and/or family members) please list their name(s):  
\_\_\_\_\_  
\_\_\_\_\_

Primary language: \_\_\_\_\_ Second Language: \_\_\_\_\_

Education: Check off as many as applicable:

\_\_\_ High School Diploma

\_\_\_ University - Masters

\_\_\_ College Diploma

\_\_\_ University - PHD

\_\_\_ University – Undergraduate

\_\_\_ Other qualifications or certificates:

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Do you have any health concerns that would need to be attended to while overseas?  
Yes \_\_\_ No \_\_\_ If Yes, please explain:

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In which other countries other than Canada have you lived?

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In which other countries other than Canada have you traveled?

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**PROGRAM OF INTEREST**

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**PERSONAL STATEMENT** (attach a separate sheet of paper if needed):  
Describe any instance where you have been associated with people and cultures other than your own. What do you feel are some of the challenges in living and working in another culture?

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How do you deal with interpersonal tensions and differences? How do you react under stress and pressure?

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**Application Form**

List any volunteer experience you have had and the length of time you participated.

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What skills/services can you offer to Bridges of Hope?

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Any CIDA (Canadian International Development Agency) experience?

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Bridges of Hope overseas volunteer program includes a significant educational component designed to provide an overview of empowerment in the lives of children, their families and their communities. After learning about this work and participating in it, we believe that volunteers will be motivated to return home to share the impact of child sponsorship and our projects with other Canadians as a passionate advocate.

Are you interested in becoming an advocate for the children that Bridges Of Hope serves?

Yes  No

If yes, please describe how you see yourself engaging fellow Canadians in your role as an advocate.

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Please describe any experience (formal / informal) that you have had in sharing or advocating on behalf of others (include one-to-one opportunities with friends, formal group presentations, as well as any opportunities that you have had to share with others something that is important to you. This may include speaking on behalf of a cause, placing posters or distributing literature on behalf of any organization.)

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**EMPLOYMENT:**

I am employed:

- Full - Time
- Part - Time
- Self - employed
- Homemaker
- Unemployed
- Retired
- Student

**OCCUPATION:**

\_\_\_\_\_ (e.g., Retail Sales, Teacher, Lawyer, Farmer, Homemaker, Student, etc...)

**PERSONAL REFERENCES**

Please list at least three people whom we may contact for character references (for example, employers, community workers, Priests, Pastors, rabbi, etc.). Please do not include family members as references.

Reference Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Address: \_\_\_\_\_

\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Alternate Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Address: \_\_\_\_\_

\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Alternate Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Address: \_\_\_\_\_

\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Alternate Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

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Reference Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Alternate Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Position: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Alternate Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship to you: \_\_\_\_\_

\_\_\_\_\_ I verify that I am willing and prepared to fundraise and/or cover my own travel expenses.

\_\_\_\_\_ I verify that I do not have a criminal record and/or have committed or plan/have planned any offences and/or acts of terrorism.

\_\_\_\_\_ I understand and agree that I will NOT hold Bridges Of Hope, Bridges Of Hope Directors, Agents, or assigned Agents liable or responsible for death, injury or disability that may result from my participation or association as a volunteer.

I hereby declare that the above information is true and complete to my knowledge.

\_\_\_\_\_  
Signature Date

**Participants under 18 years of age, please complete this page for signature of parent or guardian.**

Signature: \_\_\_\_\_  
(Legal guardian if child is under 18 years of age)

*Please sign and return with your completed application form. Keep a copy for your own records. Your application cannot be processed until we have all necessary documents.*

**Application Form**

**Authorization for Medical Treatment**

I authorize \_\_\_\_\_ or designate for the purpose of consenting to medically necessary procedures during my child's attendance at \_\_\_\_\_ for the period of \_\_\_\_\_, 20\_\_ to \_\_\_\_\_, 20\_\_ for the purposes of \_\_\_\_\_.

The team leader will seek to communicate with the child's parent or legal guardian prior to treatment, whenever possible.

By signing below, I authorize medical treatment on my behalf.

Child's name: \_\_\_\_\_

Child's Alberta Health Care Number \_\_\_\_\_

Parents/Legal Guardian Names: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Legal guardian if child is under 18 years of age)

Date: \_\_\_\_\_

Emergency Phone No. \_\_\_\_\_

List any allergies, sensitivities to medications, and pre-existing medical conditions below.

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If you have any questions, please contact us at: 1-877-460-6036

If you are sending your application by mail, please send to:

**Bridges of Hope.**

#223, 207 - 13 Street N. Lethbridge AB T1H-2R6

Phone: (403) 380-3844 Fax: (403) 380-3990

Toll Free (877) 460-6036 You can also Email us at: [info@bridgesofhope.ca](mailto:info@bridgesofhope.ca)