



Our vision: A society in which people with a mental illness are valued and treated as equals

Volunteer Application Form

Service for which you are volunteering: _____

Supervisor/Coordinator's name _____

First Name: _____ Last Name: _____

Address: _____

_____ Post Code: _____

Phone number: _____ Mobile number: _____

Email: _____ Are you over 18 years of age? _____

Occupation: _____ Are you willing to undertake training? _____

Are you prepared to commit to the Fellowship for twelve months? _____

How much time are you able to commit to (eg per week, per month) _____

Do you have any previous volunteering experience?

Why are you interested in volunteering for the Schizophrenia Fellowship?

Do you have any knowledge of or experience with schizophrenia or other mental illnesses? If yes, please elaborate.

How did you find out about volunteering with the Fellowship?

References: Please provide 2 personal/professional referees, indicating whether they are personal or professional referees and the name of the organization.

Name: _____ Contact phone: _____

Name: _____ Contact phone: _____

Date: _____ Signature: _____