



**HAWSPETS**  
Humane Animal Welfare Society

701 Northview Road, Waukesha, WI 53188  
262.542.8851 www.hawspets.org

**Volunteer Coordinator: Sara Stoss**  
262.542.8851, Ext. 120 volunteer@hawspets.org

**CITIZEN PROJECT  
VOLUNTEER APPLICATION**

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

Do you have court ordered community service hours to complete? Please circle :      Yes      No

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone#: \_\_\_\_\_

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

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Referring Agency: \_\_\_\_\_

Referring Agency Contact Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Please list any medical concerns or conditions that could possibly affect your ability to volunteer:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of any sex-related or child-abuse crime?      Yes      No

I understand that the Citizen Project is a six week program and participants meet every Tuesday, 4:00pm-5:30pm, every Saturday, 3pm-5pm, and I am available to volunteer at these times.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**AGES 14-17, PLEASE HAVE A PARENT OR GUARDIAN COMPLETE THE OTHER SIDE**



## PARENTAL CONSENT FORM

-Required for Citizen Project participants ages 14-17 only.

I hereby give permission for my son/daughter (name): \_\_\_\_\_  
to participate as a volunteer in the Citizen Program at the Humane Animal Welfare Society of Waukesha  
County, Inc. I certify that my son/daughter is \_\_\_\_ years of age and that his/ her birth date is  
\_\_\_\_\_.

My signature indicates that I am aware of and consent to my child's involvement in the program. I release and  
hold harmless the Humane Animal Welfare Society of Waukesha County, Inc., its agents and employees from  
responsibility or liability arising out of the above named child's participation.

I understand there are certain risks in dealing with animals. I certify that my child is covered under my health  
insurance policy should injury take place while volunteering or participating and I will be responsible for his/  
her medical bills.

Parent name (please print): \_\_\_\_\_

Signature of parent: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_