

# Montana Association for the Blind

## 2025 Volunteer Form

If this form is not accessible [CLICK HERE](#)

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMERGENCY CONTACT NAME AND PHONE NUMBER: \_\_\_\_\_

\_\_\_\_\_

REFERENCE (NAME / PHONE NUMBER): \_\_\_\_\_

\_\_\_\_\_

DATES AND TIMES AVAILABLE TO VOLUNTEER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NUMBER OF HOURS DESIRED: \_\_\_\_\_

AREAS OF EXPERIENCE: \_\_\_\_\_

DO YOU NEED ACCOMMODATIONS? IF SO, PLEASE DESCRIBE (*LARGE  
PRINT, BRAILLE*): \_\_\_\_\_

LANGUAGE(S) SPOKEN: \_\_\_\_\_

HOW DID YOU HEAR ABOUT THE MAB? \_\_\_\_\_

WHY WOULD YOU LIKE TO VOLUNTEER FOR THE MAB? \_\_\_\_\_

\_\_\_\_\_

HAVE YOU VOLUNTEERED BEFORE? IF SO, WHEN AND WHERE \_\_\_\_\_

\_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Send completed form to: [mabadmin@mabsop.org](mailto:mabadmin@mabsop.org)**

**Or Mail to:**

**Montana Association for The Blind**

**1302 24th St. W., PMB 134**

**Billings, MT 59102**