



Downtown Oshawa BIA NEEDS You!

Your BIA is coming to life and we need your help to make it the very best it can be! The opportunities to get involved are limitless and the amount of time you spend is up to you. Please fill out this form and forward it to your BIA today!

Name: _____

Address: _____

Telephone: _____

The best time to contact time: _____

I want to get involved!

I would enjoy (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Doing office work | <input type="checkbox"/> Planning festivals/ cultural events |
| <input type="checkbox"/> Writing newsletter features | <input type="checkbox"/> Working on a board and/or committee |

I would like to help with the following committee-related work:

- | | |
|---|--|
| <input type="checkbox"/> Activity surveys and follow-up | <input type="checkbox"/> Building improvements planning |
| <input type="checkbox"/> Event planning | <input type="checkbox"/> Graphic design |
| <input type="checkbox"/> Marketing Working Group member | <input type="checkbox"/> Fundraising |
| <input type="checkbox"/> Media relations | <input type="checkbox"/> Partnership development |
| <input type="checkbox"/> Poster/Newsletter distribution | <input type="checkbox"/> Events Working Group member |
| <input type="checkbox"/> Research of funding sources | <input type="checkbox"/> Beautification Working Group member |
| <input type="checkbox"/> Volunteer recruitment | <input type="checkbox"/> Working with local schools |
| <input type="checkbox"/> Other: _____ | |

I would like to volunteer:

- | | |
|--|--|
| <input type="checkbox"/> On a regular basis | <input type="checkbox"/> Two to 10 hours a month |
| <input type="checkbox"/> About an hour a week | <input type="checkbox"/> About two hours a month |
| <input type="checkbox"/> On short, finite projects | <input type="checkbox"/> On a committee |
| <input type="checkbox"/> On a subcommittee(s) | <input type="checkbox"/> As needed |

Please send to: admin@downtownoshawa.ca



Emergency Contact and Medical Information

PERSONAL

Name: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

MEDICAL

Family Doctor: _____ Doc Phone: _____

Doc Address: _____ Health Card # _____

Allergies: _____ none

Medications: _____ none

Medical conditions: _____

Hospital of choice: _____

EMERGENCY CONTACTS

Contact #1

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Contact #2

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

ADDITIONAL INFORMATION
