

All applications submitted between the months of October-April must be submitted with verification of receipt of the flu vaccine from the provider



VOLUNTEER APPLICATION

PLEASE CIRCLE THE DAYS/TIME AVAILABLE AND INTERESTS

NAME: _____ DATE OF BIRTH: _____

SS# _____

ADDRESS:

Street: _____ City/Town: _____ ZIP: _____

EMAIL ADDRESS _____ PHONE: _____

Previous Volunteer Experience: _____

Work Life Experience: _____

Education: _____

Other Special Interest/Training: _____

Health – Please List any Limitations _____

FOR HIGH SCHOOL SERVICE HOURS ONLY

What high school are you attending _____

How many hours do you need to complete? _____ By what date? _____

Special interests or hobbies that you would be willing to share? _____

Do you have a future interest in healthcare? _____

FOR COLLEGE INTERNSHIPS ONLY

What school are you attending? _____

What is your area of study? _____

List one or two goals you have for your internship? _____

How many hours do you need to complete? _____ By what date? _____

Days Available: SUN MON TU WED TH FRI SAT

(Students must do volunteer service during the week)

Hours Available: MORNING AFTERNOON EVENING

Please Circle

****Please Have Two (2) References Returned**

Complete Entire Application Form. Incomplete Forms Will Not Be Considered.

APPLICANT'S SIGNATURE _____ DATE: _____

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