LITTLETON REGIONAL HEALTHCARE

ADULT & JUNIOR VOLUNTEER APPLICATION

Name: _____ Date: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Email address: _____Date of birth: _____

Health concerns or special needs that may impact volunteering: _____

_____

Do you speak any language other than English? ❑ Yes ❑ No

If yes, what language(s): _____

Name of person to call in event of an emergency: _____

Their phone number: _____ Relationship to you: _____

Day(s) of the week you are available to volunteer: _____

Areas/departments that interest you: _____

_____

Times you are available: _____

Do you have special talents and/or computer skills? ❑ Yes ❑ No

If yes, please explain: _____

If under 18 years of age, please have a parent/guardian sign off on this application giving permission to volunteer:

_____ _____

(PRINT) (SIGN)

Please complete this form and return to: ***Gail Clark, Director of Marketing & Community Relations***
Littleton Regional Healthcare - 600 St. Johnsbury Road
Littleton, NH 03561 - gclark@lrhcares.org - 603.444.9304