

SIXTH AVENUE PSYCHIATRIC REHABILITATION PARTNERS, INC.
VOLUNTEER REGISTRATION FORM

Name _____ Date _____

Address _____

Home phone number _____ Work number _____

Person to be contacted in an Emergency Name _____ Telephone _____

Available for volunteering:
Day (s) of the week _____ Hours _____

Are you presently employed? _____ Do you have transportation? _____

Are you under 18 years of age? _____ If yes, Parent or Guardian Signature _____

Any information that you would like for us to be aware of? (Problems lifting, allergies, sight or Hearing impairment) _____

Special skills, training, educational background, interests, and hobbies: _____

What area of Sixth Avenue Psychiatric Rehabilitation Partners, Inc. are you interested in volunteering? _____

Have you been a volunteer for another agency, scouts, church? _____

List three references that are not family members including telephone number or address:

1. _____
2. _____
3. _____