SLRC
St. Lawrence Rehabilitation Center

Marlene Stankus
Director of Volunteers
2381 Lawrenceville Road
Lawrenceville NJ 08648

609-896-9500 Ext. 2260
609-620-5972 Fax
mstankus@slrc .org email
www.slrc.org website

JUNIOR VOLUNTEER APPLICATION

Date:_____

Name:_____ Male Female
Last First Middle (circle one)

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____

Parent Cell Phone: _____ E-mail:_____

Date of Birth:_____ Referred by:_____

High School:_____Year of graduation:_____

Career Interest:_____

Previous Volunteer Work:_____

I am available: _____School Year _____Summer _____ Winter Break _____ Spring Break

Volunteer Work Preferred: _____

Day(s) and Times (s) Preferred:_____

Special skills, interests and hobbies:_____

_____

Physical Limitations:_____

Physician:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Relationship:_____

* *

Junior Signature: _____ Date: _____

Parental Permission: I hereby give my permission for my child to perform volunteer service at St. Lawrence Rehabilitation Center. I understand the responsibilities involved and will support my child in complying with the volunteer requirements, including obtaining a two-step Tuberculosis Test.

Parent / Guardian Signature: _____ Date: _____