YOUTH ADVISORY COUNCIL APPLICATION

DEADLINE for application is March 28th

DATE:_______________

NAME:________________________________

HOME PHONE:________________

ADDRESS:____

____________City/State/Zip Code

BIRTHDATE:__________ AGE:_____

PARENT/GUARDIAN INFORMATION:

FATHER'S NAME:________________________

EMPLOYER:______________________________

HOME PHONE:___________________

WORK PHONE:_____________________

MOTHER'S NAME:________________________

EMPLOYER:_______________________________

HOME PHONE:___________________

WORK PHONE:_____________________

PHYSICIAN NAME:___________________________

PHONE:________________

NAME OF SCHOOL YOU ATTEND:

____GRADE:______

ADDRESS OF
SCHOOL:____

SCHOOL ACTIVITIES/HOBBIES/SKILLS:

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HAVE YOU VOLUNTEERED AT CHILDREN'S BEFORE?________
IF SO IN WHATAREA?________________________________

WHY DO YOU WANT TO BE ON THE YOUTH ADVISORY COUNCIL?

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WHAT QUALITIES WOULD YOU BRING TO THE YOUTH ADVISORY

COUNCIL?____

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PLEASE NAME A PERSONAL REFERENCE WHO IS NOT A RELATIVE:

____
PHONE:___________________________

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If accepted as a Youth Advisory Council member, I agree to abide by all rules and regulations which govern both Volunteers and Employees. I agree to observe all rules of safety and conduct.

SIGNATURE:_____________________________________

If you completed the application please send back to Kristine Jansen at:

The Children's Hospital
c/o Kristine Jansen, B220
13123 E. 16th Ave.
Aurora, CO 80045

Or Fax to (720)777-7254 **Or** Email to jansen.kristine@tchden.org