



CAROLINA
THERAPY CONNECTION

"Informing families, enriching lives, changing futures"

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Volunteer/Shadowing Application

Thank you for your interest in volunteering at Carolina Therapy Connection. If you feel like you meet the requirements and are willing to commit to a time period, please complete this application and we will contact you with further instruction.

APPLICATION DATE:	
NAME:	
HOME ADDRESS:	
PHONE NUMBER:	
EMAIL ADDRESS:	
EMERGENCY CONTACT:	
DATE OF BIRTH:	
I AM CURRENTLY:	IN HIGH SCHOOL: YES OR NO SCHOOL NAME: IN COLLEGE: YES OR NO COLLEGE NAME: PROGRAM: OTHER:
LIST ANY VOLUNTEER OR COMMUNITY INVOLVEMENT ESPECIALLY RELATING TO CHILDREN, MEDICAL, OR THERAPY/REHAB SERVICES:	

PLEASE SELECT WHICH PERIODS YOU ARE AVAILABLE:	FALL (SEPT-DEC)	SUMMER (JUNE-AUG)	SPRING (JAN-MAY)
DAYS AVAILABLE:	HOURS AVAILABLE:		
<input type="checkbox"/> MONDAY			
<input type="checkbox"/> TUESDAY			
<input type="checkbox"/> WEDNESDAY			
<input type="checkbox"/> THURSDAY			
<input type="checkbox"/> FRIDAY			
EXPERIENCE OBJECTIVE:	PLEASE PROVIDE A WRITTEN OBJECTVIE FOR YOUR VOLUNTEERING/SHADOWING EXPERIENCE.		

PRINT NAME

VOLUNTEER SIGNATURE

OFFICE DIRECTOR

___/___/___
DATE