Children's Therapy Network LLC

VOLUNTEER APPLICATION

Welcome to Children's Therapy Network! We are excited to have volunteering with us and our clients. Please complete the following application and return to the office at your earliest convenience.

CONTACT INFORMATION

Name: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip code: _____
Phone: _____ E-mail address: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Phone: _____

WORK/EDUCATIONAL EXPERIENCE

School experience:

_____
_____

Work experience:

_____
_____

Volunteer experience:

_____
_____

Experience with children with disabilities:

_____
_____

PERSONAL INFORMATION

Have you ever been convicted of a crime? ☐Yes ☐ No
If yes, please
explain_____
We may run a background check for our records. Do you agree to this? ☐Yes ☐No
What are you hoping to get out of volunteering at CTN?

_____
_____

Will you need any special documentation of your volunteer time with us?

_____
_____

How many hours per week are you hoping to volunteer with CTN?

_____

_____

What is your availability?

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____