VOLUNTEER APPLICATION JUNIOR AUXILIARY

Galion Community Hospital

Volunteer Services Office
Galion Community Hospital
269 Portland Way South
Galion, Ohio 44833

Name_____ Date of Birth_____

Address_____

City_____State_____Zip_____

School_____Grade_____

Phone___(419) _____E-mail_____

Parents/Guardian name (please print) _____

School and Community Affiliations (clubs, churches, sports, etc.)

_____

Reason for Volunteering_____

_____

I hereby apply for membership in the Junior Auxiliary Program. I agree to comply with the requirements and regulations of the service.

Date_____ Applicant Signature_____

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