



VOLUNTEER GROUP FACILITATOR APPLICATION

Name: _____ Date: _____

Address: _____ Phone: (H) _____

City: _____ State: _____ Zip: _____ Phone: (W) _____

Email address: _____ Fax: _____

Date of Birth: _____ Occupation: _____

Workplace address: _____

Volunteer experience: _____

Employment experience: _____

Number of children(if any): _____ Ages: _____

Name of close friend or relative to contact in an emergency: _____

_____ Phone number: _____

Physician's name: _____ Phone number: _____

Hospital of choice in case of emergency: _____

Any medical history about which we should be aware?: _____

How did you hear about the Alcove? _____

What influenced you most in your decision to volunteer at the Center? _____

Is co-facilitating a group of children, teens or adults at the Center your goal for attending training?

Yes _____ No _____

Is co-facilitating a group of children, teens or adults at the Center your goal for attending the training?

Yes _____ No _____

Have you had a major loss or grief within the last year? _____

Have you had a major loss or grief within your life? _____

Please list the names, addresses, and phone numbers of two references:

1. _____

2. _____

Please return this form to:
The Alcove Center for Grieving Children and Families
376 Tilton Road- Rear
Northfield, NJ 08225

Fax Number: 609-484-3188
Email: mindy@thealcove.org