



Volunteer Information Form

Name: _____

Home Address: _____

City: _____ Zip: _____

Home Telephone: (_____) _____ DOB: _____

Occupation: _____

Name of Company: _____

Work Address: _____

City: _____ Zip: _____

Work Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Languages Spoken: _____

Are you a cancer survivor? YES _____ NO _____

Day and times available to Volunteer?

Mon from _____ am pm to _____ am pm

Tue from _____ am pm to _____ am pm

Wed from _____ am pm to _____ am pm

Thu from _____ am pm to _____ am pm

Fri from _____ am pm to _____ am pm

Clerical support.

Fund Raising support.

Patient Assistance.

Volunteer for League's Events.

Briefly tell us how you became interested in volunteering with League Against Cancer: _____
