Chronic Migraine Awareness, Inc.
Volunteer Application

Personal Information

Name: _____ Date: _____

Address: _____DOB: _____

City/State/Zip: _____

Phone #: _____

Email: _____

Professional Information

Organization: _____

Title/Job Description:_____

Professional Affiliations: _____

Volunteer Placement

To help us determine where best to place you, please let us know what your interests and experiences are;

Fundraising Events: _____

Support Groups (Facebook and local): _____

Social media: _____

Patient Education: _____

Please list your areas of expertise; good with people, social media, fundraising, education:

_____

_____

_____

Please describe other volunteer activities you've been involved with:

_____

_____

_____

Please let us know why you'd like to volunteer with CMA:

_____

_____

_____

Please provide two references;

Name:_____

Address:_____

City/State/Zip:_____

Home phone:_____Work phone:_____

Name:_____

Address:_____

City/State/Zip:_____

Home phone:_____Work phone:_____

Signed:_____ Date:_____

Please return to CMA

nhbonk@gmail.com

4117 Circle Court

Williamsville, N.Y. 14221