RETIREE ACTIVITY OFFICE

VOLUNTEER APPLICATION

Last Name:___________________________ First:_________________________ Middle Initital:_______

Street Address____

City /State/zip_________________________________

Phone Number(s):____

e-mail address:____

Service:____________________ Number of Years of Service:_______________

Spouse Name (if applicable)____

Volunteer Area You Are Signing up for: (circle choice(s))

Retiree Information Services (BLdg 210, Room 168)

Hospital Information Desk (main lobby of hospital)

Satellite Pharmacy (at the Main BX area)

Other:____

Preferred Day for Volunteering? If none indicate all AM/PM? If none indicate either.

Fill out AF Form 2583 Section 1, Identifying Information, items 1 through 7.

Fill out DD Form 2793, Part I, sign & date Part II 9a./b.