Hearing Loss Association of America
New York City Chapter

VOLUNTEER FORM

Name: _____

Address: _____
Street City State Zip

E-mail Address: _____ Phone: _____

Do you have a hearing loss? ___Yes ___No

If yes, are you able to communicate on the phone? ___Yes ___Yes, but not easily ___No

Availability: Day(s) of week: _____ Time(s) of day: _____

Employment/Volunteer/Education History

_____

_____

_____

_____

Please check area(s) of interest.

____Chapter programming ____Marketing ____Development ____Writing

____Website management ____Public Relations ____Walk4Hearing ____Advocacy

Other (specify)_____

How did you first hear about HLAA?

___Member ___Friend ___Audiologist ___HLAA Website ___Other (specify) _____

Thank you for returning this form to Hearing Loss Association of America – New York City Chapter, P.O. Box 602, Radio City Station, New York, NY 10101-0602.

If you have any questions, email info@hearinglossnyc.org