WCFR Volunteer Form

Name: ______________________________________ **Credential(s):** ______________

Address: ____

City: ___________________________ **State:** ___________ **Zip:** ____________

Phone: _______________________ **Email Address:** ____________________________

Hospital/Organization: ____

I am interested in helping in the following way(s):

☐ **I would like to host a fundraiser for WCFR.**

☐ **I am interested in helping at WCFR events and activities.**

☐ **I am interested in participating on WCFR educational/training programs.**

By signing and submitting this form, you consent WCFR to contact you for future volunteering opportunities.

_______________________________________ ____________________

(NAME) **(DATE)**

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