



DEPARTMENT OF HEALTH  
COMMUNITY NURSING SERVICE  
111 N. 6TH STREET--PO BOX 1508  
VINELAND, NJ 08362-1508  
856.794.4261 FAX 856.794.6162

### TOBACCO AGE-OF-SALE ENFORCEMENT PROGRAM

#### Teenage Volunteer Application

Name of volunteer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/Zip: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Phone (H): \_\_\_\_\_

Street Address: \_\_\_\_\_ (W): \_\_\_\_\_

City/Zip: \_\_\_\_\_

#### Questions:

Circle:

- 1. Parental permission is required. Would that be a problem?..... Yes No
- 2. Do you consider yourself a regular smoker?..... Yes No
- 3. Do you understand that the program is confidential and strictly voluntary? ..... Yes No
- 4. Are you available: After School..... Yes No  
    Saturdays..... Yes No  
    During Summer..... Yes No

5. Please explain why you would like to be considered for this community service?

Signature: \_\_\_\_\_

\*\*\*\*\*

Reference's Comments: