



HELPER / VOLUNTEER FORM

Note: Some volunteer activities are single event commitments; some may involve a bit more of your time or involvement. You decide your level of involvement!

Name: _____

Address: _____
Street City State Zip

E-mail Address: _____ Phone: _____

Do you have a hearing loss? _____ Yes _____ No

What is your preferred way to be contacted? _____ Phone, _____ Text or _____ E-mail

Please check area(s) of interest.

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Chapter Development | <input type="checkbox"/> Marketing | <input type="checkbox"/> Website Assistant |
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Writing | <input type="checkbox"/> Event Planning |
| <input type="checkbox"/> Publicity | <input type="checkbox"/> Social Media | <input type="checkbox"/> Legislative |
| <input type="checkbox"/> Fund Raising | <input type="checkbox"/> Advertising | <input type="checkbox"/> Outreach |

Please share any related areas of special interest or expertise:

How did you first hear about HLAA?

Member Friend Audiologist HLAA Website Other (specify) _____

Thank you for returning this form to:

HLAA New York State Association; P.O. Box 1002 Fairport, NY 14450

If you have any questions, please email: hlaa.newyorkstate@gmail.com

You will be contacted by a HLAA Member to further discuss possible volunteer opportunities.