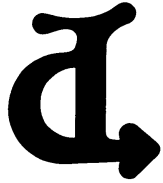


Share Mentoring Program



Duarte Parks and Recreation Department
1600 E. Huntington Drive
Duarte, CA 91010
(626) 357-7931, Ext. 203

Name: _____ Soc. Sec. No.: _____

Address: _____ City: _____ Zip: _____

Telephone: Home (_____) _____ Work (_____) _____

Place of Birth: _____ Date of Birth: _____

Marital Status: _____ Spouse's Name: _____

Name, Age, and Sex of Children: _____

Language(s) Spoken Other Than English: _____

Race: _____ Religion: _____

Eyes: _____ Hair: _____ Height: _____ Weight: _____

Have you ever been convicted of a felony: _____ Yes _____ No

Calif. Driver's License No.: _____ Ever Suspended/Revoked? _____

Do you have auto insurance? _____ Has your auto insurance ever been canceled? _____

If yes, why? _____

Auto Insurance Company: _____ Policy No.: _____

Emergency Contact Name: _____ Phone: (_____) _____

Hobbies, Interests, and Special Skills: _____

The Share Mentoring Program requires a minimum commitment of 6 months and four hours per month.

Days of Week Available: S M T W TH F S Hours: From _____ to _____

S M T W TH F S Hours: From _____ to _____

S M T W TH F S Hours: From _____ to _____

S M T W TH F S Hours: From _____ to _____

Educational History:

Did you complete High School? _____ If so, Where? _____

Other Education: _____

Military History: _____ Military Service No.: _____

Job History: _____

Previous Volunteer Work or Related Experiences: _____

Why do you want to be a Share Mentor?

Would you like to mentor a pregnant teen mother? _____

How did you hear about the City's Share Mentoring Program? _____

REFERENCES:

Please provide the names, addresses and phone numbers of the individuals you wish to use as references in items 1 through 5 listed below. We prefer local references who have known you for at least two years. Please use at least two references who are not relatives. I understand that by providing this information I am authorizing the City to contact my references.

Employer:

1. Company Name: _____
Supervisor's Name: _____ Phone: (_____) _____
Address: _____ City: _____ St.: _____ Zip: _____

Physician:

2. Name: _____ Phone: (_____) _____
Address: _____ City: _____ St.: _____ Zip: _____

Other References:

3. Name: _____ Phone: (_____) _____
Address: _____ City: _____ St.: _____ Zip: _____

4. Name: _____ Phone: (_____) _____
Address: _____ City: _____ St.: _____ Zip: _____

5. Name: _____ Phone: (_____) _____
Address: _____ City: _____ St.: _____ Zip: _____

Signature of Applicant

Date