



The Lawrence E. Whelan  
**BeginAgain**  
 CHILDREN'S GRIEF CENTER  
 a program of  
 Halifax Health - Hospice of Volusia/Flagler

**Return to:**  
 BeginAgain Children's Grief Center  
 655 N. Clyde Morris Blvd.  
 Daytona Beach, FL 32114

## FACILITATOR APPLICATION

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INITIAL \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (DAY) \_\_\_\_\_ PHONE (EVENING) \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

CURRENT EMPLOYER (IF EMPLOYED) \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

TITLE \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

### Previous Employment:

DATES	EMPLOYER	TITLE	OCCUPATION	SUPERVISOR
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Education: \_\_\_\_\_

What reasons do you have for becoming a facilitator? \_\_\_\_\_

What are your expectations of participation in this program? \_\_\_\_\_

Is there anything likely to prevent you from keeping your one-year commitment? \_\_\_\_\_

Describe your experience with youth (volunteer, professional, personal). \_\_\_\_\_

Which participants would you feel most comfortable spending time with?  
 Please indicate your first, second and third choices plus check a child, adult or teen preference.

Children  Adults  Teens

List first, second and third choice of group you would like to be in:

\_\_\_\_ **Little's** (ages 3-5), meets in the evening every other week.      \_\_\_\_ **Teens** (ages 13-19), meets in the evening every other week.

\_\_\_\_ **Latency** (ages 6-12), meets in the evening every other week.      \_\_\_\_ **Adult Group**, meets in conjunction with other groups.

Reason for preference: \_\_\_\_\_

When are you available? Please list the times you are available in the boxes below:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
MORNING					
AFTERNOON					
EVENING					

What talents or skills do you have that would be of interest to children and which would you be willing to share with your group?

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Please identify any physical or medical conditions that may affect your ability to participate in this program.

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Who should we contact in an emergency?

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Are you on public record as a sex offender or physical abuser?  Yes  No

Have you been convicted of a felony?  Yes  No

Are you abusing drugs or alcohol?  Yes  No

Have you ever been hospitalized for a mental illness?  Yes  No

If yes, when? \_\_\_\_\_

Are you currently taking medications?  Yes  No

If yes, what medication(s)? \_\_\_\_\_

If yes, for what condition(s)? \_\_\_\_\_

Please give a history of your own experience with death (list dates):

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Due to the nature of the BeginAgain Children's Grief Center program, we reserve the right to reject or accept potential volunteers.

NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_