Georgia Gwinnett College
School of Health Sciences
Nursing Program

VOLUNTEER VERIFICATION FORM

Student Information

Name: ____GGC ID#__________________
(Please Print)

Email: ____ (must state a valid email address)

Student Signature:____

Date: _______________________

Volunteer Representative

Information below to be completed by representative/individual overseeing the volunteer event(s)

Name of Organization: ____

Address: ____
Street Address City State Zip

Type of work the student engaged in:

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Start Date: ______________ End Date: _______________ Hours Completed____________

Name of Volunteer Representative: ________________________________
Signature of Volunteer Representative: ____
Title: ____ Phone Number:_________________
Date: ______________________