SUNY Downstate Medical Center
450 Clarkson Avenue
Brooklyn, NY 11203

Phone: 718-270-3992
Fax: 718270-1924

# Adolescent Education Program: Teens Helping Each Other
# Peer Leadership Initiative

## Application

*(Please print all information clearly and legibly in ink.)*

DATE: ____/____/____

FIRST NAME: ____________________ LAST NAME: ________________________

DATE OF BIRTH: ____/____/____ PHONE NUMBER: ___________________

HOME ADDRESS: ________________________ APT.: _________ ZIP CODE: ________

SOCIAL SECURITY #: ____________________ GENDER: ___________

SCHOOL: _______________________________ GRADE: ____________

COUNSELOR'S NAME: ___________________ AVERAGE: _________

INTERESTS, HOBBIES, TALENTS: _______________________________________________

EMAIL ADDRESS: _____________________________________________________________

PARENT/ GUARDIAN'S NAME: __________________________________________________

PARENT/ GUARDIAN'S NUMBER: ________________________________________________

## PLEASE ANSWER THE FOLLOWING QUESTIONS:

Why do you think it is important for young people to learn about sexual health information such as HIV/AIDS, STDS?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What do you think is a major health concern facing teenagers today? (Ex. Violence, HIV/AIDS, Teen Pregnancy, STDS, Etc.)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Why would you like to become a Peer Leader and serve your community?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

How will being a Peer Leader help you to achieve your future goals?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## Work Experience:

Company: ________________________ Years Worked: ________________________

Supervisor's Name: ________________ Phone Number: _______________________

Job Duties: ______________________________________________________________

Company: ________________________ Years Worked: ________________________

Supervisor: _______________________ Phone Number: _______________________

Job Duties: ______________________________________________________________

## Volunteer Experience:

Company: ________________________ Years Worked: ________________________

Supervisor: _______________________ Phone Number: _______________________

Job Duties: ______________________________________________________________

## References:

Reference Name: _______________________ Phone Number: _______________________

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## Personal Statement:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please return completed application to: SUNY Downstate Medical Center
Teens Helping Each Other:
Peer Leadership Initiative
450 Clarkson Avenue Box 1240
Brooklyn, NY 11203