



**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: _____

Reference Name: _____ Phone Number: _____

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