



WELLNESS WORKS WONDERS

SY2017 WELLNESS AMBASSADOR VOLUNTEER INTEREST FORM

Please PRINT

NAME: _____

EMAIL: _____

WORK PHONE #: _____

CELL PHONE #: _____

DEPARTMENT: _____

TSHIRT SIZE: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S EMAIL: _____

The Arlington EAP appreciates your interest in the APS Wellness Works Wonders Program

1. Please tell us how you live a life of wellness (or why you would like to begin living a life of wellness) and why you want to be an Ambassador.

2. Please share specific examples of how you would communicate Wellness information and opportunities to your colleagues and throughout your department.

3. Please share at least one event/program idea you think Wellness Works Wonders should organize that will inspire and motivate employees.

Signature indicates you are able to commit the required time and have received your supervisor's approval to submit this application.

Signature: _____

Date: _____

Principal/Supervisor Signature: _____

Date: _____