



## Massachusetts Long Term Care Ombudsman Volunteer Application

First name: \_\_\_\_\_

Last name: \_\_\_\_\_

Street: \_\_\_\_\_

Street 2: \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

**Return this form to: [jenny.beaujean@mass.gov](mailto:jenny.beaujean@mass.gov)**