

**Devon-Stafford Little League**  
**Volunteer Verification Form**

**Season:** \_\_\_\_\_ **Year:** \_\_\_\_\_

Player(s) Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_

Function(s): \_\_\_\_\_

Verified by:

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Verifier Function: \_\_\_\_\_

Head Coach, Division Director, Board member, etc.

Estimated Hours (need 4 hours per player to qualify) \_\_\_\_\_

(Maximum is 2 players - 8 hours minimum)

**Mail to:** Devon-Stafford Little League

PO Box 674

Devon PA 19333-0674

**or**

**Hand it to:** President, Board Member, Division Director or Treasurer