

VOLUNTEER APPLICATION

NAME (SURNAME) _____ GIVEN NAME _____

STREET ADDRESS _____ APT.# _____ CITY _____ PROV. _____ POSTAL CODE _____

HOME PHONE NUMBER _____ EMAIL ADDRESS _____

DATE OF BIRTH: (Optional) MONTH ____ DAY ____

Emergency Contact Information: Name/Relationship/Phone # _____

WHY ARE YOU LOOKING TO VOLUNTEER?

School Initiative. *If yes, please circle the appropriate option:*

Community hours

Career Focus

School Program: _____

Or

Adult or Senior looking to give back to the Community

Or

I have been a patient or family member of a patient

CURRENT OCCUPATION: _____

PREVIOUS VOLUNTEER EXPERIENCE: _____

ADDITIONAL FLUENT LANGUAGES: _____

SPECIAL SKILLS/EXPERIENCE: (Example: Computer experience, Training, Sewing, Languages, etc.) _____

AREAS OF VOLUNTEERING YOU WOULD BE INTERESTED IN: Check All That Apply

Dieu Drop In (Coffee Shop)

Gift Gallery (hospital gift shop)

Nevada Break Open Tickets

Delta Bingo(Auxiliary Fundraiser)

HDS Auxiliary Member

Admin/Office(HDS Foundation)

Gardening

Entertainment (If so, what kind: _____ e.g.: piano, dance)

Eucharistic Ministry/Pastoral Services

Recreation Therapy

Specialty Areas:

Patient Advisor

Rehab (Patient Care)

Speech Language Pathology

AVAILABILITY: (Please Specify Morning/Afternoon/Evening/Days of the Week/Weekend):

HAVE YOU EVER BEEN CONVICTED OF A FEDERAL OFFENCE FOR WHICH NO PARDON HAS BEEN GRANTED?

I CONFIRM THAT THE INFORMATION GIVEN IS TRUE, COMPLETE AND ACCURATE. (The hospital will keep all information confidential)

Applicant's Signature _____

Date _____

PLEASE GIVE THE NAMES OF TWO REFERENCES (NOT RELATIVES). I UNDERSTAND THAT THE VOLUNTEER DEPARTMENT MAY CONTACT THE REFERENCES SHOWN.

FULL NAME	EMAIL	OR	PHONE NO.	RELATIONSHIP
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THE FOLLOWING STATEMENTS WILL BE REVIEWED AT ORIENTATION

COMMITMENT:

All potential long term volunteers are asked for a time commitment in order to provide on-going volunteer services throughout the hospital. Hospital staff use valuable time in training, evaluating and supervising volunteers and count on them to be reliable. The undersigned volunteer agrees to commit a minimum of three months of Volunteer Service to the Hotel Dieu Shaver Health and Rehabilitation Centre barring any special circumstances that may arise including termination due to inappropriate actions. All high school students applying for Volunteer Service must adhere to this policy regardless of the nature of the school program. (Students must be 16 years of age or older and in secondary school before applying to Volunteer Services).

IMMUNIZATION & TB SURVEILLANCE:

Everyone carrying on activities in the Hospital is required by law to have health screening, including a two-step tuberculin test. More information will be provided to prospective volunteers.

I understand that this volunteer placement is unpaid and will not lead to employment.

I agree that I am participating in Hotel Dieu Shaver Health and Rehabilitation Centre Volunteer placement program for charitable purposes, or casual observation and I do this on my own initiative.

I have read and understand all the above statements and I agree to abide by the hospital policies.

Applicant's Signature

Date