

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 check 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 Cafe (Coffee Shop)

☐ Gift Gallery (Gift Shop)

☐ Nevada Break Open Tickets

☐ Delta Bingo (Auxiliary Fundraiser)

☐ HDS Auxiliary Member

☐ Admin/Office (HDS Foundation)

☐ CDA Workshops

☐ Recreation Therapy

Friendly Visitor

☐ Eucharistic Ministry/Pastoral Services

Wayfinding

Specialty Areas: ☐ Patient Advisor ☐ 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	AND	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.

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