Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

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)***

☐ ***Gardening*** ☐ ***Recreation Therapy***

☐ ***Eucharistic Ministry/Pastoral Services***

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	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.

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**

Form II-VOL-1

Hotel Dieu Shaver Health & Rehabilitation Centre
Volunteer Services

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