

VOLUNTEER SERVICES APPLICATION

PLEASE INDICATE WHICH SITE YOU ARE APPLYING TO:

☐ Alexandra Hospital ☐ Tillsonburg District Memorial Hospital

Please Print Clearly

LAST NAME: _____ GIVEN NAME: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

DATE OF BIRTH: _____

OCCUPATION: _____ (PAST/PRESENT)

EMPLOYER: _____

LANGUAGE(S) SPOKEN: _____

IN CASE OF EMERGENCY, NOTIFY:

Name & Relationship to applicant (spouse/child/etc.)

Address: _____

Phone: _____ Cell phone: _____

Current Volunteer Work: _____

Other Volunteer or Community Service Experience: _____

Do you have any health issues that could affect your ability to volunteer? ☐ Yes ☐ No

If yes, please specify

How did you hear about volunteering at the hospital?

☐ Social Media ☐ Presentation ☐ Display ☐ Friend ☐ Hospital ☐ Other: _____

What qualities do you possess that would enhance our team? _____

Please list any special skills, training or work experience you feel would be useful in a volunteer role:

What are your hobbies or interests:

Are you interested in, *(please select areas of interest to you)*

☐ Patient Contact Volunteering? **OR** ☐ Non-Patient Contact Volunteering?

Time Availability: (Please check off times you would be available to volunteer)

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Morning							
Afternoon							
Evening							

References

There are several steps involved to become part of the Volunteer Services Program at Alexandra Hospital and Tillsonburg District Memorial Hospital.

The first of which is to complete this application and provide us with two references.

Reference one:

Name: _____ Affiliation: _____

Telephone: _____ E-mail Address: _____

Reference two:

Name: _____ Affiliation: _____

Telephone: _____ E-mail Address: _____

I hereby authorize and release from all liability my present/previous employer and/or educational institution/volunteer placement to provide Volunteer Services, with reference information concerning me, including but not limited to achievement, performance, attendance, employment/ educational history, disciplinary information and reason for separation of employment and/or education.

Applicant's: Signature _____ Date: _____

Please read and check ☒ before signing:

I certify that I am 14 years of age or older and that the information in this application is correct to the best of my knowledge and I understand that any misrepresentation or omission may result in my dismissal if I am accepted as a volunteer.

I understand that not everyone who applies is accepted as a volunteer.

I understand that prior to confirmation of a program and shift time, volunteers must submit the results of a negative 2-step Tuberculosis (TB) test and provide proof of immunization.

I understand that I am required to obtain a Police Check. (We will provide this information for you at the time of interview).

Applicant's Signature: _____ Date: _____

Personal information contained on this form is collected pursuant to the Public Hospitals Act and the Freedom of Information and Protection of Privacy Act (FIPPA), and will be used for the purpose of volunteer selection and placement at AHl or TDMH. We will not share this information otherwise without permission from the applicant and their guardian.

Please complete this application and forward to

**Integrated Volunteer Coordinator
Ashley Hominick**

Alexandra Hospital, Ingersoll ~ 29 Noxon Street, Ingersoll ON N5C 1B8 ~ 519-485-1700 ext. 8234
Tillsonburg District Memorial Hospital – 167 Rolph St., Tillsonburg ON N4G 3Y9 – 519-842-3611 ext. 8234
Ashley.Hominick@rrhs.ca