Alexandra Hospital Ingersoll
*Partnering to keep healthcare close to home.*

VOLGISTICS #

# VOLUNTEER SERVICES APPLICATION

***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?

❑ Newspaper ❑ Presentation ❑ Display ❑ Friend ❑ Hospital ❑ Other:_____

What qualities do you have 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?

- ☐ Friendly visiting
- ☐ Clinic Portering
- ☐ Assisting Patients Cardiac Program
- ☐ Gift Shop
- ☐ Clerical work

**Time Availability:** (Please check '✓' 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.

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 16 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 Vulnerable Sector Check. (We will provide this information for you at the time of interview).
- ☐ I understand that orientating a volunteer to our hospital is costly, therefore, I agree to make a regular commitment to AHI for a minimum of 6 months and/or a minimum of 60 hours service.

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 AHI. We will not share this information otherwise without permission from the applicant and their guardian.

Please complete this application and forward to

**Coordinator of Volunteer Services**

**Volunteer.Services@ahi.ca**

**Alexandra Hospital, Ingersoll**

**29 Noxon Street**

**Ingersoll, ON N5C IB8**

Phone: 519-485-1700 ext. 8234 / Fax: 519-485-9606