Volunteer Services Application Form

Site of Interest ____________________

Name: ___________________________________ *Mr.*○ *Mrs.* ○ *Ms.*○ *Miss* ○ √

*Address:*________________________________ *Box #*________________________

*Town:*__________________________________

*Email Address:*_________________________

*Phone Number:*________________________ *Cell #*_________________________

Please list your employment history:
Previous and/or current volunteer experiences:
Please list any skills, interests, hobbies and personal experience and training relevant that would be an asset to your volunteer placement:
Are there any physical limitations or health problems that you feel we should be made aware that might affect your volunteer placement?
Do you speak, read or write another language? *Yes or No (circle)* *What language?*___________________________
Which department of the hospital are you interested in volunteering? *Meals on Wheels Delivery/Driver* *Seniors Van Driver* *The Gift Shop* *Recreation Program* *Nevada Booth (located at D.H. Food Mall & Extra Foods)* *Palliative Care* *Pastoral Care* *Other:*____

Times available to Volunteer:

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*
a.m./p.m	*a.m./p.m*	*a.m./p.m*	*a.m./p.m*	*a.m./p.m*	*a.m./p.m*	*a.m./p.m*

Availability: ***Weekly _____ Monthly _____ Occasional ________***

Immunizations: ***Flu Shot ________ Tuberculin Skin Test ___________***

References that may be contacted. Please indicate an employment and character reference:

1. Name Address Relationship Phone Number

____

2. Name Address Relationship Phone Number

____

I authorize the North of Superior Healthcare Group to contact the individuals and/or organizations listed above for the purpose of obtaining reference information. I hereby give permission to these individuals and/or organizations to release to the North of Superior Healthcare Group all relevant information requested.

Signature of Applicant ____ Date:_____________________

**Criminal Reference Checks will be required.*

<u>Please note:</u> When the desired department is selected, there may be additional forms to be filled out pertinent to the department and requirements for the program.

I hereby certify that the information set forth in this application is true and complete. I understand that omissions or false statements will be considered sufficient cause for rejection of application or discharge. If accepted as a volunteer for the North of Superior Healthcare Group, I agree to adhere to all policies and procedures of NOSH.

X ____

Signature of Applicant

Date: ______________________

Please forward this completed form to:

Lorelle Bertin,
Community Programs Coordinator,
Wilson Memorial General Hospital

Eliz Gibbons,
Seniors Recreation Coordinator
Wilson Memorial General Hospital

Charlene Schintz,
Volunteer/Fund Raising Coordinator
Wilson Memorial General Hospital

Personal information contained on this form is collected for the purpose of maintaining current volunteer records. Questions about collection should be directed to Charlene Schintz, Coordinator of Fund Raising/Volunteers, cschintz@nosh.ca, 807-229-1740, ext 224