

VOLUNTEER APPLICATION

The information on this form will help us to find the most satisfying and appropriate volunteer placement for you. Kindly provide us with as many details as possible. Thank-you!

PLEASE PRINT

FOR OFFICE USE ONLY Date Received: _____ Interview Date: _____ Referred By: _____ Computer #: _____ WCB Exempt: ()

I wish to volunteer my time at:

- GREY NUNS COMMUNITY HOSPITAL
- MISERICORDIA COMMUNITY HOSPITAL
- EDMONTON GENERAL CONTINUING CARE CENTRE

PERSONAL

Name _____
(First) _____ (Last)

Home Address _____ Home Telephone _____

_____ email _____

City _____ Postal Code _____ Bus. Telephone _____

In case of Emergency Contact:

_____ (Name) _____ (Relationship) _____ (Home Phone) _____ (Bus. Phone)

EXPERIENCE

Volunteer Experience or Community Involvements:

Work Experience:

Education, Training or Courses Taken:

STUDENTS ONLY: Name of School: _____ Grade: _____

SKILLS

Special skills, languages and/or interests that you may like to share in this volunteer position:

FOR OFFICE USE: CRC _____ Imz _____ TB _____ Reference _____

TIME AVAILABLE FOR VOLUNTEER WORK

Total Hours per Week: _____ Regularly each week? Yes No
Preferred time of shifts: _____ If 'No', how often: _____
Preferred days: _____

AREAS YOU ARE INTEREST IN VOLUNTEERING

1ST: _____ 2ND: _____ 3RD: _____

WHAT DO YOU HOPE TO GAIN FROM YOUR VOLUNTEER EXPERIENCE?

REFERENCES: (*Most appropriate references are Employers, Volunteer Supervisors, Teachers, Co-Workers)

I authorize the Caritas Health Group to obtain references from the persons listed below:

- Name _____ Phone: (H) _____ (W) _____
Address: _____ Relationship to you: _____
- Name _____ Phone: (H) _____ (W) _____
Address: _____ Relationship to you: _____

IMMUNIZATION/HEALTH INFORMATION

Provincial regulations require all health care workers (staff and volunteers) to provide us with the following information prior to placement:

- Date and results of T.B. Test (Mantoux Test) done within the past six months (proof required).
Date: _____ Results: _____
If positive, results of Chest X-ray. Date: _____ Results: _____
- Proof of MMR Immunization if born after 1970 _____
- Have you had Chicken Pox?** Yes No Unknown
- For your protection, please make us aware of any health conditions which may impact your ability to perform the volunteer tasks required: _____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I, _____, hereby give permission to the Caritas Health Group to obtain information regarding my previous employment, education and/or volunteer background including a Security Clearance Check. A copy of this authorization shall be as valid as the original.

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____