

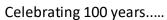


Celebrating 100 years.....

VOLUNTEER APPLICATION

Personal Information					
☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Ot	ther Preferred F	irst Name:			
Last Name:	First Name	:			
Address:					
City: Postal Code					
Telephone: Home: () Cell: ()					
E-Mail: Citizenship: Canadian Other:					
Age Group: Under 19 19-25 26-40 41-60 Over 60					
Have you had a flu shot? Y - N Have you had your Covid shots? Yes - 1 - 2 - 3 No					
Why are you interested in volunteering for	·us?				
, , ,					
Check what type of volunteer programs interest you? Hospital Reception Medical Equipment Loans Cottage Thrift Store					
☐ Gift Shop ☐ Ambulatory Day Care ☐ Bus Outings (TRIM)					
Can you volunteer on a regular basis? Yes No, what times are you available for volunteer work?					
Would the times be regular, or would they need to change frequently? Regular Change					
Please indicate blocks of specific times in the		Friday	Caturday	Cundou	
Monday Tuesday We	ednesday Thursday	Friday	Saturday	Sunday	
PM					
List any hobbies / skills / interests/ experiences that would be helpful in your volunteering:					
Do you speak and/or write languages other than English: Yes No					
If YES, please specify:					
Office Hea Only			Continued (on back page	
Office Use Only: Rec'd Date:	On Hold Date	2:			
Comments / Notes:					
Comments / Notes:					







<u>VOLUNTEER</u> : Are you presently a vol	lunteer?		
If yes, where:	How long?		
	erience:		
EMPLOYMENT: Are you currently en	mployed: Yes No Full Time Part Time Casual		
Current Employer:			
May we contact you at work:	Yes No		
Previous Employment: (attach resum	ne if you wish)		
Area of Study:	Year / Grade :		
	ning you have:		
Have you any specific health care tra	ining: Yes No If yes, please describe:		
and one business or volunteer relate	es (not relatives that have known you for at least 6 months; one personal ed: (Please inform your references that they may be contacted)		
Personal Relationship to you:	Email:		
Name:	Telephone: ()		
Personal Relationship to you:	Email:		
Emergency Information: In case of eme	ergency, contact Name:		
Telephone: Home: ()	Business: () Cell: ()		
Please read the following carefully be	efore signing this application		
"I	(Print your name) confirm that the information in this volunteer		
• •	rstand and agree that any omission or misrepresentation with respect to the sal of volunteer placement and may be cause for immediate termination. II		
,	<u>ck is required.</u> I authorize Mission Healthcare Auxiliary to contact the		
references listed and give permission to	these references to release all relevant information requested."		
understand, and give permission for Mi	ission Healthcare Auxiliary to keep a record of my personal information and		
	and that this information may be disclosed to any party with legal and prope		
nterest, and I release the agency from a	ny liability whatsoever for supplying such information.		
Signature:	Date:		