



Mission Health Care Auxiliary Society JUNIOR VOLUNTEER APPLICATION



Personal Information

School: _____ Grade: _____ Average: _____

Last Name: _____ First Name: _____ Middle Name: _____

Preferred First Name: _____

Address: _____ City: _____

_____ Postal Code: _____ Phone: _____

Home: _____ Cell: _____ Other: _____

E-mail: _____ Birthdate: _____
Month Day Year

Preferred Method of Contact: ☐ Telephone ☐ Email

** Have you had the Flu Shot this year? ☐ Yes. ☐ No – COVID Shots 1 - 2 - 3

Emergency Contact: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Do you have previous experience as a volunteer? ☐ Yes ☐ No

If "Yes, where? _____

Why would you like to be a Candy Striper or Junior Volunteer? _____

How did you hear about us? _____

Hobbies, Interests & Community Affiliations

Hobbies, Interests, Training or Previous Hospital Work: _____

Community Affiliations (Church, Clubs, etc.): _____

Confidentiality

I understand that in the course of my volunteer work I may be exposed to information of a **CONFIDENTIAL** nature pertaining to patients and/or their families.

I will consider as **CONFIDENTIAL**, all information which I may hear directly or indirectly and will seek no information in regard to a patient except as it pertains to my volunteer assignment.

I will uphold the traditions and standards of this Hospital and will safeguard its reputation by maintaining the highest standards of confidentiality.

Signature: _____

Date: _____
Month Day Year

For additional information contact: Cynthia Butcher at: 604.852.8501