



North Renfrew
Family Health Team

Volunteer Application

Personal Information

First Name:		Last Name:			
Home Telephone #:		Cell Phone #:		Other Telephone #:	
Email:			Preferred Method of Communication:		
			<input type="checkbox"/> Telephone <input type="checkbox"/> Email <input type="checkbox"/> Both		
Address:				Apt. #/Suite #:	
City:		Prov:		Postal Code:	
Languages Spoken:					
Emergency Contact Name:			Relation:		Telephone #:

Availability - Please check (✓) the box to indicate the days and times that you would be available or please feel free to indicate specific times within the box:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Please indicate any additional details of availability:

Volunteer Experience

Have you volunteered previously? YES, please fill in information below NO

Please include information regarding your volunteer experience:

Name of Agency:	
Length of Services:	
Volunteer Duties:	

Work Experience and Education (Attach resume if preferred)	
Are you presently employed?	<input type="checkbox"/> NO <input type="checkbox"/> YES (<input type="checkbox"/> Part-time <input type="checkbox"/> Full Time)
Current work experience:	
Previous work experience:	
Are you presently a student?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Name of School:	
Current Grade Level/Degree:	
Tell us about your interests or skills:	
<input type="checkbox"/> Gardening <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Administrative <input type="checkbox"/> Computers <input type="checkbox"/> Music - Playing an Instrument <input type="checkbox"/> Music - Singing <input type="checkbox"/> Outdoors	<input type="checkbox"/> Event Planning <input type="checkbox"/> Reading <input type="checkbox"/> Games/Cards <input type="checkbox"/> Bowling <input type="checkbox"/> Visiting <input type="checkbox"/> Other: _____ _____
Please check (✓) which roles you are interested in volunteering for:	
<input type="checkbox"/> Mealtime Assistant (assist Residents/Patients with feeding) <input type="checkbox"/> Friendly Visitor (one-on-one visits; chatting, walks) <input type="checkbox"/> Programs Assistant (lead programs, i.e. Bingo) <input type="checkbox"/> Outing Escort (porter/guide Residents to activities) <input type="checkbox"/> Palliative Volunteering or Visiting <input type="checkbox"/> Nutrition Cart Assistant (help distribute snacks and drinks) <input type="checkbox"/> Computer Tutor (teach Residents basic computing) <input type="checkbox"/> Music/Entertainer (play instruments) <input type="checkbox"/> Pet Therapy (visit Residents/Patients with pets – additional paperwork may be required) <input type="checkbox"/> Reading Program (read in groups or to Residents/Patients) <input type="checkbox"/> Writing Program (writing in groups with Residents/Patients) <input type="checkbox"/> Pastoral Program (visit Residents/Patients, provide spiritual support, read and sing hymns) <input type="checkbox"/> Other – please specify: _____	
<p><i>** If you are interested in volunteering at the Gift Shop or Whistle Stop, please let us know to provide with you a separate volunteer application and information for these services which are provided by the Auxiliary.</i></p>	
Do you have suggestions for our services, please include them here:	
What is the reason you want to volunteer?	
<input type="checkbox"/> Desire to help others <input type="checkbox"/> Interest in community involvement <input type="checkbox"/> Gain work-related experience <input type="checkbox"/> Build resume <input type="checkbox"/> Immigration purposes <input type="checkbox"/> Other: _____ <input type="checkbox"/> School requirement; number of hours needed: _____	

How did you hear about our Volunteer Program?

- Website Family/Friend School/Teacher Staff/Volunteer
 Parish Doctor Social Services TV/Newspaper
 Community Organization Other:(*please specify*):_____

References

By signing the Volunteer Application form, I hereby authorize the organization to obtain information regarding my previous employment and/or volunteer experience from the references included below:

1. Name:_____ Role:_____
- Email address (preferred):_____
- Telephone #:_____ Bus. #:_____ Ext.# _____
2. Name:_____ Role:_____
- Email address (preferred):_____
- Telephone #:_____ Bus. #:_____ Ext.# _____

Additional Information

Allergies:

Do you carry an Epi Pen? Yes No

Are you willing to provide a police record check with vulnerable screening?

Yes No

* All volunteers are subject to a police record check with a vulnerable sector screening, which can be obtained at the local police detachment at no costs. (*Letter to be provided upon returned application.*)

All volunteers are required to submit a copy of their immunization record to ensure necessary immunizations are up to date according to the organizations requirements for MMR-V as well as documentation for TB Skin Tests must be provided. Bloodwork and additional immunizations may be required. (*Letter to be provided upon return of application.*)

- I will provide proof of TB Skin Tests as per organizational requirements.
 I will submit proof of my immunity as required.

Are you willing to get an annual flu shot? (To assist during outbreaks) Yes No

Are you willing to provide proof of COVID-19 vaccination? Yes No

Are you in good health and able to perform the duties required of a Volunteer? Yes No

Do you require any accommodations to make your volunteer experience with our organization better for you?

No Yes, please specify: _____

Do you require assistance in the event of an emergency?

No Yes – *If yes, we will set up a time for you to meet with our Occupational Health Nurse to create an Individual Emergency Response Plan.*

First Name: _____ **Last Name:** _____

I hereby verify that the above information is deemed to be true and accurate to the best of my knowledge. I also understand that falsification, misrepresentation, omission and/or misleading statements will result in immediate termination of my volunteering with the Deep River and District Hospital, Four Seasons Lodge and/or the North Renfrew Family Health Team.

Applicant Signature

Date

Witness Signature

Date

Please return this completed form to the Volunteer Services Program Assistant.

We thank you for your interest in volunteering your time with our organization.