Deep River & District Hospital Auxiliary

Membership Application

All Applications to work in the Hospital are subject to a Police check (no charge for volunteers)

Name: (Please Print) ____

Full Address: ____

Town: ________________________________ **Postal Code:** ______________

Phone No: Home: ______________________ **Business/Cell:** ______________

Email: ____

Please indicate where and what your job was: ____________________________

Preferred Hours: Mornings_____ **Afternoons** _____ **Evenings** _____ **Weekends** ______

Please check the area and the activities you are interested in.

Retail – Whistle Stop (no police check)	
Sorting items in the Whistle Stop	
Working the desk in the Whistle Stop	
Retail – Gift Shop (no police check)	
Working shifts in the Gift Shop	

The following require a Police Check

Evening Nutrition		**Breast Screening (OBSP)**	
		Four Season's Lodge	
Palliative Care		Entertainment	
		Reading/Crafts/Games	
		Events (inside/outside)	
		Bingo	
		Baking	
		Day Trips	
		Cards/Board Games	
		Meal Assistance	

_________________________________ _________________________

Applicants Signature **Date**

Deep River & District Hospital Auxiliary

Statement of Confidentiality

I, the undersigned, do willingly promise to hold in the strictest of confidence any information about a patient, his/her family, staff member, member of the medical staff, other volunteer, or the hospital that is learned while serving as a volunteer for the Hospital Auxiliary. I will make no reference to the identity of any patient, his/her admission to the hospital, records, diagnosis or treatment. I will not discuss unnecessarily with other volunteers, staff members, patients, or persons within or outside the hospital any information I have acquired as a volunteer. Furthermore, I will use in a responsible manner, information gained in the course of my service at the Deep River & District Hospital.

I understand that such compliance is an on-going condition of volunteering and that any non-compliance with the said policy may result in determining me ineligible for future volunteering.

____ _______________________________

Signature of Volunteer **Date**

Reference Release Authorization

I, ____________________________________ hereby authorize the following references to release information regarding my appropriateness to serve as a volunteer with the Deep River & District Auxiliary.

I release listed references from all liability arising from release of information.

Name	Telephone Number
1. ___________________________________	_____________________
2. ___________________________________	_____________________
3. ___________________________________	______________________

____________________________________ ______________________

Signature of Applicant **Date**

Deep River & District Hospital Auxiliary

Student Application - requires

Parental Consent Form

(Name of applicant) _____________________________________ has applied to volunteer with the Deep River & District Hospital Auxiliary. In order for your child to have a productive experience, it is essential that parents help their child be successful.

Please read and sign below if you would like the Auxiliary to continue processing your child's application.

I understand that my child, named above, wishes to become a volunteer with the Deep River & District Hospital Auxiliary. I hereby give my permission for him/her to serve as such. I understand that this will include an orientation and training necessary for the safe and responsible performance of duties of the position. I acknowledge that regular attendance and adherence to the Hospital's policies and procedures is required. I further acknowledge that he/she will not receive compensation for the services contributed other than community service credit.

Name of Parent: ____

Signature of Parent: ____ Date: ________________________

For Office Use ONLY

References Completed	**Orientation & Forms**
Emergency Procedures	**Parental Consent**
Photo ID	**Probation Completed**
Gift Shop	**Whistle Stop**
	Other