**Deep River & District Hospital Auxiliary**

**Membership Application**

**Name: (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone No: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business/Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No Police Check is Required for Whistle Stop or Gift Shop**

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

|  |  |
| --- | --- |
| **Retail – Whistle Stop**  |  |
| Sorting items in the Whistle Stop |  |
| Working the desk in the Whistle Stop |  |
| Would you work as a spare |  |
| Preferred day to work at Whistle Stop |  |
|  |  |
| **Retail – Gift Shop**  |  |
| Working shifts in the Gift Shop |  |
| Would you be on the spare list |  |

**Preferred Hours for Volunteering at Gift Shop**

**Mornings\_\_\_\_\_ Afternoons \_\_\_\_\_ Evenings \_\_\_\_\_ Weekends \_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Applicant 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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_