



Volunteer Resources  
 5546 Portage Road  
 Niagara Falls, ON  
 L2E 6X2  
 Tel: 905-378-4647 ext. 54927  
 Fax: 905-357-0303  
 amccollum@niagarahealth.on.ca  
 www.niagarahealth.on.ca

**APPLICATION FOR VOLUNTEER SERVICE**

Date <small>(year/month/day)</small>	Resume attached <input type="checkbox"/>	All sections of this Application Form must be completed in full as a supplement to any resumes or attachments.	
<b>PERSONAL DATA</b>			
Last name		First name	
Address			
City	Province	Postal Code	
Home phone number ( )		Work phone number ( )	
E-mail address:			
Are you 14 years of age or over? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been convicted of a criminal offence for which a pardon has not been granted or for which a pardon has been granted and subsequently revoked? <input type="checkbox"/> No <input type="checkbox"/> Yes- please list the offence(s), date(s), convictions(s)			
Have you pleaded guilty to, or been found guilty of, any criminal offence outside of Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Position desired	Department	Site	
<b>PAST AND PRESENT VOLUNTEER EXPERIENCE</b>			
Organization	Functions/responsibilities	Date	
Organization	Functions/responsibilities	Date	

**SKILLS**

Indicate any skills, qualifications or experience which you feel would especially relate to the volunteer positions for which you have applied.

**GENERAL**

Have you ever been employed by the Niagara Health System or any of its hospital sites?

Yes  No

From	To	Department	Site
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Have you ever been a volunteer for the Niagara Health System or any of its hospital sites?  Yes  No

From	To	Site
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**REFERENCES- do not list relatives**

Name	Telephone	Relationship to applicant

Name	Telephone	Relationship to applicant

**AUTHORIZATION TO RELEASE REFERENCE INFORMATION**

I understand and agree that the Niagara Health System will request information from the above named references in connection with my application for a volunteer position. I authorize the above named references to release all such information as requested. I also agree that no liability or damage shall accrue to the above named references as a consequence of their releasing such information.

Signature	Date (year/month/day)
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**DECLARATION**

1. I understand that any offer of a volunteer position would be conditional upon the following:
  - a. Following our "Communicable Disease Surveillance Program", everyone carrying out activities in patient care areas must have a 2-step tb test. Documented proof of immunity to chicken pox, measles, and rubella is also required;
  - b. my photograph being taken for identification purposes;
2. I understand that if accepted for a volunteer position, I agree to comply with the conditions of the volunteer position and the policies of the hospital.
3. I understand that if any statements made by me on this or any other document are untrue or misleading, this application may be rejected or will constitute sufficient grounds for termination of service.
4. I will not disclose or use, during or subsequent to my volunteer service with the Niagara Health System, any information (written, verbal, electronic, or any other form) relating to patients, employees, volunteers or Hospital business.

Signature	Date (year/month/day)
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