niagarahealth

Extraordinary Caring. Every Person. Every Time.

Niagara Health
General Inquiries
905-378-4647 ext.44630
volunteer@niagarahealth.on.ca
www.niagarahealth.on.ca

Date / / (month / day / year)	All sections of this application form must be completed in full. ***Please attach a resume.*** Please print clearly.

APPLICANT INFORMATION

First Name:	**Last Name:**

Address:

City:	**Province:**	**Postal Code:**

Primary phone number: ( )	Alternate phone number: ( )

E-mail address:

Are you over the age of 16: ☐ No ☐ Yes

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? ☐ No ☐ 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? ☐ No ☐ Yes

PLEASE INDICATE YOUR AVAILABILITY

Time:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

INTERESTS (PLEASE CHECK ALL AREAS OF INTEREST)

☐ Patient Interaction	☐ Long Term Care	☐ Auxiliary
☐ Greeting & Information	☐ Retail (ex. gift shop)	☐ Non-Patient Interaction
☐ Clinics (assist staff & patients)	☐ Office	☐ Walker Family Cancer Centre

** Please note that vacancies vary at the different sites and may not be available at your preferred site**

PREVIOUS NIAGARA HEALTH INVOLVEMENT

Have you ever been a volunteer for the Niagara Health System or any of its hospitals? ☐ Yes ☐ No

From To	Department	Site Welland Site

Have you ever been employed by the Niagara Health System or any of its hospitals? ☐ Yes ☐ No

From To	Department	Site Welland Site

SKILLS

List your skills, qualifications or experience which relate to volunteering at the hospital.

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Please tell us why you would like to volunteer at Niagara Health. What goals or experience would you like to achieve?

HOSPITAL SITE (Please check which Site you would like to be considered for)

☐ Welland Hospital ☐ St. Catharines ☐ Greater Niagara (Niagara Falls)

☐ Doulgas Memorial (Fort Erie) ☐ Port Colborne ☐ Other:_____

PAST AND PRESENT VOLUNTEER EXPERIENCE

Organization	Role	Start and End Dates
Organization	Role	Start and End Dates

PLEASE ATTACH: TWO (2) PROFESSIONAL WRITTEN LETTERS OF REFERENCE

Letters of References. Must include Reference's name, title, relationship to you, address and contact information.

EMERGENCY CONTACT INFORMATION

First Name:		Last Name:	
Phone:		Relationship:	

Do you have any medical conditions that we should be aware of? ☐ Yes ☐ No

If Yes, please describe:

AUTHORIZATION TO RELEASE REFERENCE INFORMATION

I understand and agree that Niagara Health may 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 (mm/dd/yyyy)

DECLARATION

1. I understand that any offer of a volunteer position would be conditional upon the following:
   a. Following Niagara Health "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, mumps and rubella is also required;
   b. my photograph being taken for identification purposes;
   c. Police Criminal Record Check
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 Niagara Health, any information (written, verbal, electronic, or other form) relating to patients, employees, volunteers or Hospital business.
5. I give consent for my provided contact information to be shared within Niagara Health.

Signature	Date (mm/dd/yyyy)