|  |
| --- |
| New Volunteer Applicant□ Returning Volunteer Applicant □ Date of last activity: mm/dd/yyyy |
| **Personal and Contact Information** |
| First Name: | Last Name: | Male: □ Female: □ |
| Apt #: | Address: |
| City: | Province: | Postal Code: |
| Phone Numbers (H): | (M): | (W): |
| Email Address: |
|  **Work and Volunteer Experience**  |
| Name of Organization | Position/Duties | From (mm/yyyy) - To (mm/yyyy) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Education** |
| Highest Level of Education: | Completed □ In Progress □ |
| Name of Institution (Optional): |
| Area(s) of Study (If applicable): |
| **Availability**  |
| Shift | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday  | Saturday |
| Morning |  |  |  |  |  |  |  |
| Afternoon |  |  |  |  |  |  |  |
| Evening |  |  |  |  |  |  |  |
| **Months Available** |
| January □ | February □ | March □  | April □ | May □ | June □ |
| July □ | August □ | September □ | October □  | November □  | December □ |
|  |
| **Areas of Interest** |
| Please indicate the area(s) in which you would like to volunteer? |
| □ Information Desk/Greeter □ Meal Assistant □ Surgical Services □ Social Rehabilitation □ Patient Support for Clinics  |
| How did you hear about our program? □ Website □ Family/ Friend □ Other |
| Do you have any affiliation with HDH *(eg. Former or current staff/patient/family*)?  □ Yes □No |
| If Yes, please specify: |
| **Please read *carefully* before signed and dating the following:** |
| The Hanover & District Hospital reserves the right to accept or not accept volunteer applicants. Volunteers are placed according to their interests, skills, suitability, and the needs of the hospital. The Hanover & District Hospital reserves the right to release a volunteer from his/her volunteer position if, in the opinion of the hospital, continuance of the volunteer role could cause detriment to the hospital. I understand that false or incomplete information on this application form may disqualify me from volunteering, or result in my dismissal. |
| Applicant Signature: | Date: mm/dd/yyyy |

|  |
| --- |
| **Parental Consent- Under 18** |
| I certify that I meet the minimum age requirement of 16 years old. Yes □ No □ |
| Parent/Guardian signature is required for all applicants under the age of 18.I give consent for my child to volunteer at the Hanover & District Hospital. I understand that my son/daughter must fulfill all program commitment requirements to receive confirmation of volunteer activity. |
| Print Parent/Guardian Name: |
| Parent/Guardian Signature: | Date: mm/dd/yyyy |

Please return completed application package to:

**Hanover & District Hospital**

**Attention: Human Resources: Volunteers**

**90 7th Avenue, Hanover, ON N4N 1N1**

**Phone: 519-364-2341 ext 233 Email:** **hr@hdhospital.ca**