



Date: _____

Cumberland Health Authority
VOLUNTEER SERVICES
Application Form

A. GENERAL INFORMATION:

NAME: _____

ADDRESS: _____

_____ Postal Code: _____

PHONE: _____ E-MAIL: _____

DATE OF BIRTH (if under 18 years of age) dd/mm/yyyy: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ Phone: _____

B. SPECIFIC INFORMATION

OCCUPATION: _____

SCHOOL: _____

EDUCATION (last grade completed): _____ EMPLOYER: _____

EXPERIENCE (any related volunteer experience, certificates, work experience):

SPECIAL INTERESTS, HOBBIES OR SKILLS (people skills, crafts, computer, music, etc.):

VOLUNTEER AREAS OF INTEREST:

- | | | |
|---|--|--|
| <input type="checkbox"/> Information Booth | <input type="checkbox"/> Meal Assist Program | <input type="checkbox"/> Crafts/Activities |
| <input type="checkbox"/> Distribution of Info | <input type="checkbox"/> Reading to Patients | <input type="checkbox"/> Library |
| <input type="checkbox"/> Satisfaction Surveys | <input type="checkbox"/> Patient Errands | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> Tours | <input type="checkbox"/> Friendly Visiting | |
| <input type="checkbox"/> Other _____ | | |

WHY DO YOU WISH TO BE A HOSPITAL VOLUNTEER?

WHICH CUMBERLAND HEALTH CARE SITE ARE YOU APPLYING?

C. AVAILABILITY

BEST TIME TO CALL YOU: _____

HOURS AVAILABLE/WEEK (most shifts are 3-4 hours long): _____

DATE AVAILABLE TO START: _____

PLEASE CHECK PREFERRED TIME PERIODS AVAILABLE:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____						

TIMES OF YEAR YOU MAY BE UNABLE TO COME (due to vacation, appointments, etc.):

DO YOU HAVE A MEDICAL HISTORY OR MEDICAL LIMITATIONS THAT WE SHOULD BE AWARE OF?

D. REFERENCES

PLEASE PROVIDE 2 NON-RELATIVE REFERENCES:

Name:	_____	_____
Title/Assoc.:	_____	_____
Address:	_____	_____
	_____	_____
Phone:	_____	_____

HOW DID YOU HEAR ABOUT OUR VOLUNTEER PROGRAM?

WOULD YOU BE WILLING TO PARTICIPATE IN A CRIMINAL REFERENCE CHECK IF REQUIRED?

YES NO

E. AUTHORIZATION

I submit this application for consideration for a volunteer position with the Cumberland Health Authority. I hereby declare the information to be true and complete to the best of my knowledge. I understand if I am selected for an interview, this does not necessarily mean I will be accepted. A successful personal reference check will form part of my acceptance as a volunteer with this organization. I authorize the Cumberland Health Authority to collect personal information to verify the character references I have supplied.

_____	_____
Applicants Signature	Date

Submit Application by Mail: Maryanne Jackson
Volunteer Services
Cumberland Regional Health Care Centre
19428 Highway #2, Upper Nappan,
Cumberland County, N. S., B4H 1N6

Fax: 902-667-6306

Drop off: Volunteer Services Office
Main Floor, Cumberland Regional Health Care Centre