



ALEXANDRA HOSPITAL VOLUNTEER SERVICES APPLICATION

Please return to:
Volunteer Services
Alexandra Hospital
29 Noxon Street
Ingersoll, ON N5C 3V6
Phone: 519-485-1700 ext 8234

Date: _____

PIN # (Office use only) _____

PLEASE PRINT CLEARLY

Last Name: _____ Given Name: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business/Cell Number : _____

Email: _____

Employer: _____

Occupation: Present: _____ Past: _____

Language(s) Spoken: English Other
 French _____ Optional:

When is your Birthday? ____ / ____ / ____
Month / Day / Year

In Case of Emergency Notify: _____

Address: _____

Phone: _____ Business/Cell: _____

Do you have any health problems that could limit your activities as a Volunteer? Yes No

If yes, please specify: _____

Current volunteer work: _____

Other volunteer or community service experience: _____

How did you hear about volunteering at the hospital?

Newspaper Presentation Display Friend Hospital Other: _____

What qualities do you have that would enhance our team? _____

Please list any special skills, training or work experience you feel would be useful in a volunteer role: _____

What are your hobbies or interests? _____

Have you ever been convicted of a criminal offense for which a pardon has not been granted? Yes No

Time Availability: (Please check '✓' times you would be able to volunteer)

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Morning							
Afternoon							
Evening							

Please '✓' the service area you are interested in:

Patient contact, circle those roles that you may be interested in.

Friendly visiting/Feeding patients

Cardiac Rehab

Supportive Care

OR Clinic Post op care

Pain clinic

ED Support

NO patient contact, circle those roles that you may be interested in.

Clerical

Information Desk

Special Events

Gift Shop

Library Volunteer

References

Name: _____ Affiliation: _____

Telephone: _____ E-mail Address: _____

Name: _____ Affiliation: _____

Telephone: _____ E-mail Address: _____

I hereby authorize and release from all liability my present/previous employer and/or educational institution/volunteer placement to provide Volunteer Services, with reference information concerning me, including but not limited to achievement, performance, attendance, employment/ educational history, disciplinary information and reason for separation of employment and/or education.

Applicant's Signature: _____ Date: _____

Please read and check before signing:

- I certify that I am 16 years of age or older and that the information in this application is correct to the best of my knowledge and I understand that any misrepresentation or omission may result in my dismissal if I am accepted as a volunteer.
- I understand that not everyone who applies is accepted as a volunteer.
- I understand that prior to confirmation of a program and shift time, volunteers must submit the results of a negative 2-step Tuberculosis (TB) test and provide proof of immunization.
- I understand that I am required to obtain a Police Vulnerable Sector Check.
- I agree to make a regular commitment to AHI for a minimum of 6 months and/or a minimum of 60 hours service.

Applicant's Signature: _____ Date: _____

Print Name: _____

Personal information contained on this form is collected pursuant to the Public Hospitals Act and the Freedom of Information and Protection of Privacy Act (FIPPA), and will be used for the purpose of volunteer selection and placement at AHI. We will not share this information otherwise without permission from the applicant and their guardian.

❖ phone 519-485-1700 fax 519-485-9606 www.alexandrahospital.on.ca
❖ Volunteer Services @ AHI 29 Noxon Street, Ingersoll N5C 3V6