



Name		Home Phone	
Address		Postal Code	
E-Mail		Cell Phone	
		(Bus) Phone	

### Emergency Contact

Name		Home Phone	
Special training/volunteer experience/Work experience			
What interests you most about volunteering (particularly in a long-term care setting)? _____			
Education:			

### Please fill in the areas of interest to you

- |                   |                          |                    |                          |                     |                          |                   |                          |
|-------------------|--------------------------|--------------------|--------------------------|---------------------|--------------------------|-------------------|--------------------------|
| Church Activities | <input type="checkbox"/> | Day Program        | <input type="checkbox"/> | Outings             | <input type="checkbox"/> | Sewing            | <input type="checkbox"/> |
| Clerical          | <input type="checkbox"/> | Entertaining       | <input type="checkbox"/> | Palliative Care     | <input type="checkbox"/> | Special Events    | <input type="checkbox"/> |
| Computer          | <input type="checkbox"/> | Gift Shop          | <input type="checkbox"/> | Pet Therapy         | <input type="checkbox"/> | Teaching/Visiting | <input type="checkbox"/> |
| Crafts            | <input type="checkbox"/> | Mealtime Assisting | <input type="checkbox"/> | Recreation Programs | <input type="checkbox"/> | Work Experience   | <input type="checkbox"/> |

Do you speak other languages? If so, which? \_\_\_\_\_

Do you play a musical instrument \_\_\_\_\_

How did you become aware of our program \_\_\_\_\_

### IMMUNIZATION/HEALTH INFORMATION

Provincial regulations require all health care workers (staff and volunteers) provide us with the following information prior to placement:

1. Date and results of T.B. Test (Mantoux Test) done within the past six (6) months (proof required).

Date: \_\_\_\_\_ Results: \_\_\_\_\_

If positive, results of Chest X-ray. Date: \_\_\_\_\_ Results: \_\_\_\_\_

2. Proof of MMR Immunization if born after 1970 \_\_\_\_\_

3. Have you had the Chicken Pox?  Yes  No  Unknown

4. For your protection, please make us aware of any health conditions which may impact your ability to perform the volunteer tasks required. \_\_\_\_\_

\_\_\_\_\_

**Please check the day(s) and times that would be most convenient for you to do your volunteer work:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list the names and telephone numbers of two (2) character references or include two written references with your application. *DO NOT include names of relatives. References MUST be 18 years or older.*

Name		Phone (Home)	
Address	PC	Phone (Business)	
Name		Phone (Home)	
Address	PC	Phone (Business)	

1. My signature below certifies that the information given in this application is true and valid and authorizes St. Joseph's to contact any and all persons or organizations mentioned on this application or during a subsequent interview.
2. I understand that as a volunteer I may be exposed to personal information regarding residents, their families, staff or other volunteers. **The disclosure of this information is a violation that will lead to immediate termination of the volunteer placement and possible legal action.** Your signature below indicates that you have read and understand this policy.
3. Volunteer phone numbers are forwarded to your area of placement following acceptance as a volunteer at Covenant Health St. Joseph's Edmonton.
4. Authorization for release of information: I, \_\_\_\_\_, hereby give permission to Covenant Health St. Joseph's Edmonton, to obtain information regarding my previous employment, education and/or volunteer background including a Security Clearance Check. A copy of this authorization shall be as valid as the original.

The above information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature Date

**For Office Use Only**

Interview Date		Reference Check(s) Date	
Security Clearance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orientation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parking Pass	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Area of Placement	_____	Time/Day of Placement	_____
Start Date	_____	Placement Notice (Date)	_____

**Please mail, fax or drop off completed and signed form to Covenant Health St. Joseph's Edmonton.**