

Volunteer Application Form

Thank you for your interest in pursuing a volunteer opportunity at the Espanola Regional Hospital & Health Centre. Please complete this form and return it to the Volunteer Engagement Department.

Volunteer Engagement Department
 Espanola Regional Hospital & Health Centre
 825 McKinnon Dr. Espanola Ontario, P5E 1R4

Tel: (705) 869-1420 ext. 3074
 info@esphosp.on.ca

PERSONAL INFORMATION

Name: _____

Address: _____ City: _____ Postal Code: _____

Home Telephone: _____ Other Telephone: _____

Email Address: _____

Date of Birth: _____ *Note: All applicants must be 14 years of age or older.*
 Month / Day / Year

Gender: _____ Language(s) Spoken: _____

Health Restrictions / Limitations: _____

How did you find out about our volunteer program?
 Referral Event Website School Facebook Newspaper Radio

Are you currently an inpatient at the Espanola Regional Hospital & Health Centre? Yes No
Note: To ensure that quality patient care remains a priority at the Espanola Regional Hospital & Health Centre, volunteer applications will not be accepted from inpatients.

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Telephone: _____

Family Physician: _____ Telephone: _____

ADDITIONAL INFORMATION

Educational Background:

High School Diploma <input type="checkbox"/>	
College Diploma <input type="checkbox"/>	Field of Study: _____
Undergraduate Degree <input type="checkbox"/>	Field of Study: _____
Post-Graduate Degree <input type="checkbox"/>	Field of Study: _____
Professional Designation <input type="checkbox"/>	Field of Study: _____
Certification <input type="checkbox"/>	Field of Study: _____

For High School Students Only:

_____ Grade _____ Name of School _____ Name of Homeroom Teacher

Professional / Work Experience:

Special Interests, Skills and Hobbies:

Community / Volunteer Experience:

I am interested in volunteering at the following Espanola Regional Hospital & Health Centre location:

Espanola Regional Hospital

Espanola Nursing Home

Foundation



I am interested in the following area(s):

General / Public

Acute Care

I will commit to volunteering for:

Six Months

More than Six months

Note: We also consider summer students who are available to volunteer for 2-3 months.

I am available to volunteer:

Time \ Day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

I like to take extended vacations during:

Summer months

Winter months

VOLUNTEER AGREEMENT

1. If I am accepted for a volunteer position, I agree to comply with the guidelines of the volunteer position and will adhere to the policies and procedures of the Espanola Regional Hospital & Health Centre and Volunteer Engagement Department.
2. I understand that the volunteer uniform and photo ID card are the property of the Espanola Regional Hospital & Health Centre and must be worn at all times when volunteering in the hospital. Upon termination as a volunteer, I will immediately return the aforementioned items to the Volunteer Engagement Department.
3. I agree to my photograph being taken for identification and/or media purposes.
4. I confirm that the information provided in this application is accurate, and I authorize investigation of all statements made in this application.

Signature of Applicant

Date