

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: Month / Day / Year Note: All applicants must be 14 years of age or older.										
Gender: Language(s) Spoken:										
Health Restrictions / Limitations:										
How did you find out about our volunteer program? O Referral O Event O We		O Facebook	O Newspaper	O Radio						
Are you currently an inpatient at the Espanola Regional Hospital & Health Centre? O Yes O 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 O										
College Diploma O	Field of Study:									
Undergraduate Degree O	Field of Study:									
Post-Graduate Degree O Professional Designation O	Field of Study:									
Certification O	Field of Study:									
•	rieiu di Study.									
For High School Students Only:										
Grade	Name of School			Name of Homeroom Teacher						

Profess	sional / Work Expe	erience:									
Special Interests, Skills and Hobbies:											
Community / Volunteer Experience:											
I am interested in volunteering at the following Espanola Regional Hospital & Health Centre location: O Espanola Regional Hospital ▼ I am interested in the following area(s): O General / Public O Acute Care											
I will commit to volunteering for: O Six Months O More than Six months Note: We also consider summer students who are available to volunteer for 2-3 months.											
I am av	ailable to volunte	er:									
	Time \ Day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun			
	Morning										
	Afternoon										
	Evening										
I like to	take extended va	cations duri	ng:								
	O Summer mont	hs O	Vinter months	;							
			VOL	UNTEER A	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.											
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										