

PLEASE ENSURE ALL QUESTIONS ARE COMPLETED AS FULLY AS POSSIBLE. PLEASE PRINT

LAST NAME:	FIRST NAME:
ADDRESS:	PHONE: (HOME):
	(CELL):
	DATE OF BIRTH:
EMAIL:	
EMERGENCY CONTACT:	
RELATIONSHIP:	PHONE:
LANGUAGES SPOKEN: ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> SIGN <input type="checkbox"/> OTHER:	

I am interested in volunteering at the: Smiths Falls site or the GWM (Perth site)

AREAS OF INTEREST: SF (Smiths Falls) GWM (Perth)				
<input type="checkbox"/> MEAL ASSIST (SF/GWM)	<input type="checkbox"/> INFORMATION DESKS (SF/GWM)	<input type="checkbox"/> GIFT SHOP (SF/GWM)	<input type="checkbox"/> TEA & TOAST (SF/GWM)	<input type="checkbox"/> CLINICS (SF/GWM)
<input type="checkbox"/> HELLP LOTTERY (GWM)	<input type="checkbox"/> PORTERING (GWM)	<input type="checkbox"/> TOURTIERES (GWM)	<input type="checkbox"/> NEWSLETTER (GWM)	<input type="checkbox"/> CRAFTS (GWM)
<input type="checkbox"/> EXECUTIVE (GWM)	<input type="checkbox"/> FUNDRAISING (GWM)	<input type="checkbox"/> GARDEN (GWM)	<input type="checkbox"/> COMMUNICATION COMMITTEE (GWM)	

I AM AVAILABLE:							
TIME	MON	TUES	WED	THURS	FRI	SAT	SUN
MORNING							
AFTERNOON							
EVENING							

When you volunteer at the Hospital you must commit to joining the Hospital Auxiliary, there is a small fee per year in order to volunteer, unless you are a student. Smiths Falls fee: \$5, GWM fee, \$10

I UNDERSTAND THAT I WILL BE A MEMBER OF THE AUXILIARY AND AGREE TO PAY THE YEARLY FEE <input type="checkbox"/> YES <input type="checkbox"/> NO
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Please drop off your membership fee to the gift shop at each respected site that you are volunteering with.

CONFIDENTIALITY:

The Hospital assures the confidentiality of each patient's health information. In the course of the volunteer's contact with the patient, the patient may reveal personal or medical information. Our patients have the right to expect that all members of the health care team, including volunteers, will hold in confidence any information which may be disclosed. Volunteers must protect patients' rights.

NAME BADGE:

**Please note that our Auxiliary name badges are magnetic and could interfere with some pacemakers. Please let us know if you have a pacemaker

GWM SITE ONLY: Please print the name below how you would like it to appear on your name badge:

(ie: John Doe, J.Doe, John D)

COMMITMENT/CONSENT

- ♥ I will be punctual and carry out my duties to the best of my abilities.
- ♥ I will notify my Convener/Staff Liaison of any necessary absence from my Service as far in advance as possible.
- ♥ I will return my ID badge/parking pass and uniform when I am no longer a Volunteer
- ♥ I am willing to have my name, telephone number and email address shared with fellow volunteers, as required.
- ♥ I am over 16 years of age.

All applicants must have a criminal reference check with vulnerable sector, please contact the following Human Resources representative to obtain a letter to take to your local police station.

Smiths Falls Applicants

Tanya Gray
613-283-2330 ext 1132
tgray@psfdh.on.ca

GWM Applicants

Angela McLean
613-267-1500 ext 4265
amclean@psfdh.on.ca

I have read and understand the above information.

Signature

Date