

VOLUNTEER APPLICATION FORM

<input type="checkbox"/> NEW Applicant		<input type="checkbox"/> Returning Applicant – MM/YY you last volunteered _____	
Contact Information			
Last Name		First Name	Title
Apt/Unit #	Address- street name and number		
City		Postal Code	
Primary Phone No. <input type="checkbox"/> Cell <input type="checkbox"/> Home		Secondary Phone No. <input type="checkbox"/> Cell <input type="checkbox"/> Home	
E-mail Address:			
Program Information			
Select which program you are applying for			
<input type="checkbox"/> Year-Round Program		<input type="checkbox"/> Fall/Winter Program (September-April)	
<input type="checkbox"/> Summer Student Program (High-School July-August)		<input type="checkbox"/> Summer Student Program (Post-Secondary May-August)	
Why are you interested in volunteering with Women's College Hospital?			

Which volunteer placement category are you interested in? (Select all that apply, categories are described on our website)			
<input type="checkbox"/> Information Desk and Wayfinding	<input type="checkbox"/> Clinic Office Help	<input type="checkbox"/> Clinic Liaison	<input type="checkbox"/> Waiting Room Support
<input type="checkbox"/> Volunteer Childcare Assistant	<input type="checkbox"/> Hand Hygiene Auditor	<input type="checkbox"/> Other _____	
Are you interested in any specific departments, programs or clinics?			

Education			
Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes , please indicate:			
Name of Institution _____		Area(s) of Study (if applicable) _____	
If no , please indicate your educational background:			

Occupation			
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired			
Occupation (If retired, list previous occupation) _____			
Employer _____			
Skills			
Please describe skills and interests that may be relevant to volunteering in a hospital setting:			

Volunteer Experience

List your past volunteer experience

Name of Organization	Position	From (MM/YY) – To (MM/YY)

Availability

Check the days and times you are available to volunteer. Please note we do not have evening or weekend opportunities and the minimum number of volunteer service hours required is 3 ½ hours per week.

Morning shifts: approximately 9:00am-12:30pm

Afternoon shifts: approximately 12:30-4:00pm

Shift	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					

Comments on availability:

Emergency Contact Information

Last Name	First Name	Relationship (optional)
Primary Phone No. <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Primary Phone No. <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	

Referral Sources

How did you hear about the Volunteer Program at Women’s College Hospital?

At the hospital Friend or Family Staff Website Social Media Other _____

References

You are required to submit 2 written references with this application. References must know you in a professional capacity and cannot be family members or friends. Referees should return the forms to the applicant for submission.

Conflict of Interest Disclosure

Is the volunteer an immediate family member of any staff member at Women’s College Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Women’s College Hospital Policy 3.20.002 Employment of Relatives, defines Immediate family as: including individuals related by blood or marriage (including foster and step relationships). Immediate family is defined but not limited to father, mother, grandparent, daughter, son, husband, wife, brother, sister and in-law (in-law includes father, mother, daughter, son and brother) aunts, uncles cousins, in addition to common-law partners and same-sex partners and divorced partners. Other relatives will be considered on an individual basis.



Please read and check before signing

- All the information I have provided on this application is true. I understand that misrepresentation of any Information is cause for dismissal.
- I understand that the references I submit will be verified.
- If accepted as a volunteer, I understand a placement assignment is dependent on skills, suitability, and Hospital needs.
- If accepted as a volunteer, I understand that prior to starting a volunteer placement, I must complete the required immunization and TB screening requirements outside of Women's College Hospital.
- If accepted as a volunteer, I understand that prior to starting a volunteer placement, I must consent to a Criminal Records Check being done, that offers are conditional upon the completion of a Criminal Records Check, and that failure to complete or successfully pass the Criminal Records Check will result in an offer being rescind.
- If accepted as a volunteer, I agree to comply with the policies and procedures of Women's College Hospital and the Volunteer Resources department as outlined during orientation and training.

Signature of Applicant: _____ Date: _____

If under the age of 18, parental or legal guardian consent is required:

I give consent for my child: _____ to volunteer at Women's College Hospital.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Return to Volunteer Resources, Women's College Hospital
76 Grenville Street, Room 7409 | (T) 416-323-6400 ext. 6180 | (E) volunteer@wchospital.ca | (F) 416-323-7741

**Thank You for Your Interest in Volunteering with
Women's College Hospital!**