

RESEARCH VOLUNTEER APPLICATION FORM

Please complete all parts of this form and attach a cover letter and resume

| Personal Information | | |
|---|---|-------|
| Last Name | First Name | Title |
| 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: | | |

| Reason for applying to volunteer | |
|---|---|
| <input type="checkbox"/> Undergraduate Student | <input type="checkbox"/> Graduate Student |
| If you are a current student, please indicate: School _____ Current Year of Study _____ Academic Program _____ | |
| <input type="checkbox"/> Recent graduate looking for work experience | <input type="checkbox"/> International Medical Graduate |
| <input type="checkbox"/> Other (please detail) | |

| Affiliation |
|--|
| Do you have any prior affiliation with Women's College Hospital? (Check all that apply) <input type="checkbox"/> Employee <input type="checkbox"/> Trainee (type) _____ <input type="checkbox"/> Volunteer <input type="checkbox"/> Other _____ <input type="checkbox"/> None |

| Application Details |
|--|
| What area of research are you interested in? (Check all that apply) <input type="checkbox"/> Aging and Chronic Care <input type="checkbox"/> Hereditary Cancer <input type="checkbox"/> Health Systems Solutions and Innovation <input type="checkbox"/> Mental health <input type="checkbox"/> Musculoskeletal Health <input type="checkbox"/> Reproductive and Sexual Health <input type="checkbox"/> Women and HIV Research Program |
| Have you identified a Scientist to which you are applying? |
| Briefly describe why you are interested in the work of this Scientist: _____ _____ _____ _____ _____ |

Please list any skills you currently have that you believe would benefit WCRI:

Emergency Contact Information

| | | |
|----------------|----------------|--------------|
| Last Name | First Name | Relationship |
| Home Phone No. | Cell Phone No. | Business No. |

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 my placement as a volunteer is dependent on my skills, suitability, interests and Hospital needs
- In accordance with Women's College Hospital Policy 3.20.002, Employment of Relatives, I Declare that I am not related to anyone in the department to which I am applying

Signature of Applicant: _____ Date: _____

Please return to Coordinator Volunteer Resources, Women's College Hospital
76 Grenville Street, Room 7407 | 416-323-6400 ext. 4014 | volunteer@wchospital.ca