



VOLUNTEER APPLICATION – DELTA HOSPITAL AUXILIARY SOCIETY

PERSONAL INFORMATION

Last Name: _____ First Name: _____

Street Address: _____ City: _____

Postal Code: _____ Phone (home): _____

(Cell) _____ E-Mail: _____

Citizenship: _____ Birthday – Month _____ Day _____

Age: Under 19 19-25 26-40 41-60 over 60

Emergency Contact: _____ Relationship to You: _____

Phone: _____ : _____

INTERESTS

Why are you interested in volunteering for us?

What type of volunteer program interests you?

Thrift Shop	Gift Shop	Hospital	Lifeline	Café	Office	Communications
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What times are you available for volunteer work. Please indicate times below.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Would the times be regular, or would they need to change frequently? Regular Change

If changing often, please explain.

ABILITIES/SKILLS

List any hobbies/skills/interests/experiences: _____

Do you speak read/write any language other than English. Specify: _____

HISTORY (VOLUNTEER, EMPLOYMENT, EDUCATION, TRAINING)

Are you presently a volunteer? Yes No Where? _____

Describe relevant past volunteering: _____

Are you employed now: Yes No Where? _____ May we contact you at work? Yes No

Describe **relevant** past work: _____

If currently a student, what school/university do you attend: _____

Area of study: _____ Year/Grade _____

List any past relevant education/training you have: _____

REFERENCES

Please provide 2 references (not relatives) that have known you for at least 6 months. *(Please tell them they will be contacted).*

Personal Reference: Name: _____

Phone: _____ Cell: _____ Email: _____

Business/Volunteer Reference Name: _____

Phone: _____ Cell: _____ Email: _____

I _____ *(print your name)* confirm that the information in this volunteer application is complete and true. I understand and agree that any omission or misrepresentation with respect to the information given may be cause for refusal of volunteer placement, or if I am a volunteer of Delta Hospital Auxiliary Society/Fraser Health, may be the cause for immediate termination. I understand that a Criminal Record Check may be required for some positions. I authorize Fraser Health to contact the references listed and give permission to these references to release all relevant information requested.

I understand, and give permission for Delta Hospital Auxiliary Society/Fraser Health to keep a record of my personal information on site and that it will remain confidential. I understand that this information may be disclosed to any party with legal and proper interest, and I release the agency from any liability whatsoever for supplying such information.

Applicant Signature: _____ **Date** _____

Parental Permission (for those aged 15 to 18) - I hereby give my permission for the above named applicant to serve as a Junior Volunteer of the Delta Hospital Auxiliary Society: (signed) _____

For Office Use

Confidentiality Agreement Signed

TB Test Received

References Checked

Membership Fee Collected

Group Orientation Completed

Return completed applications to either:

- Delta Hospital Auxiliary Society, 5800 Mountain View Blvd., Delta, BC V5K 3V6 or Fax 604-946-5741, or
- Delta Hospital Auxiliary Society Thrift Shop, 4816 Delta St, Delta, BC V4K 2T7 (*Ladner*)