HANOVER & DISTRICT HOSPITAL

Volunteer Application Form

Personal and Contact Information		
First Name:	Last Name:	
Address:		
City:	Province:	Postal Code:
Phone Number:	Preferred Pronouns:	
Email Address:		

Emergency Contact Information	
First Name:	Last Name:
Phone Number:	

Work Experience		
Name of Organization	Position/Duties	From (mm/yyyy) - To (mm/yyyy)

Volunteer Experience		
Name of Organization	Position/Duties	From (mm/yyyy) – To (mm/yyyy)

Education	
Highest Level of Education:	Completed ☐ In Progress ☐
Name of Institution (Optional):	

Availability							
Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning	☐	☐	☐	☐	☐	☐	☐
Afternoon	☐	☐	☐	☐	☐	☐	☐
Evening	☐	☐	☐	☐	☐	☐	☐

Hanover & District Hospital collects personal information under the legal authority of the Employment Standards Act 2000. The purpose of the collection is to keep personal information banks current and accurate. This information may be used and disclosed for the purpose of administering your volunteer role.

Months Available					
January ☐	February ☐	March ☐	April ☐	May ☐	June ☐
July ☐	August ☐	September ☐	October ☐	November ☐	December ☐

Areas of Interest

Please indicate the area(s) in which you would like to volunteer?

□ Greeter
□ Ambulatory Care Clinic (Specialist/OBS)
□ Emergency Department
□ Restorative Care (Patient Support-Unit 1)
□ Day Surgery or Diagnostic Imaging
□ Pet Therapy

Interested in joining Hospital Auxiliary (we will pass your application to HDH's Auxiliary)
□ Gift Shop
□ Special Event Planning/Fundraising

How did you hear about our program? ☐ Website ☐ Family/ Friend ☐ Other

Do you have any affiliation with HDH *(eg. Former or current staff/patient/family)*?

☐ Yes ☐No If Yes please specify:

Please read *carefully* before signed and dating the following:

The Hanover & District Hospital reserves the right to accept or not accept volunteer applicants. Volunteers are placed according to their interests, skills, suitability, and the needs of the hospital. The Hanover & District Hospital reserves the right to release a volunteer from his/her volunteer position if, in the opinion of the hospital, continuance of the volunteer role could cause detriment to the hospital. I understand that false or incomplete information on this application form may disqualify me from volunteering, or result in my dismissal.

Applicant Signature:	Date: mm/dd/yyyy

Parental Consent- Under 18

I certify that I meet the minimum age requirement of 16 years old. Yes ☐ No ☐

Parent/Guardian signature is required for all applicants under the age of 18.

I give consent for my child_____to volunteer at the Hanover & District Hospital. I understand that my son/daughter must fulfill all program commitment requirements to receive confirmation of volunteer activity.

Print Parent/Guardian Name:

Parent/Guardian Signature:	Date: mm/dd/yyyy