|  |
| --- |
| **Personal and Contact Information** |
| First Name: | Last Name: | Male: □ Female: □ |
| Apt #: | Address: |
| City: | Province: | Postal Code: |
| Phone Numbers (H): | (M): | (W): |
| Email Address: |
| **Emergency Contact Information** |
| First & Last Name: | Relationship to you (optional): |
| Phone Number (H): | (M): | (W): |
|  **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): |
| Area(s) of Study (If applicable): |
| **Availability**  |
| Shift | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday  | Saturday |
| Morning |  |  |  |  |  |  |  |
| Afternoon |  |  |  |  |  |  |  |
| Evening |  |  |  |  |  |  |  |
| **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? |
| □ Gift Shop □ Auxiliary Executive Team □ Special Event Planning/Fundraising  |
| Please list any skills and/or hobbies: |
| □ Clerical | □ Computer | □ Knitting | □ Business | □ People | □ Sales |
| □ Other:  |
| 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 Auxiliary reserves the right to accept or not accept volunteer applicants. Volunteers are placed according to their interests, skills, suitability, and the needs of the Auxiliary. The Auxiliary 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 |

Please return completed application package to:

**Hanover & District Hospital**

**Attention: Auxiliary – Gift Shop**

**90 7th Avenue, Hanover, ON N4N 1N1**

**Phone: 519-364-2341 ext 233 Email:** **hr@hdhospital.ca**

**Auxiliary Member Application Form**

The Hanover & District Hospital is committed to providing accessible employment practices that comply with the Accessibility for Ontarians with Disabilities Act (AODA). Please notify us if you require accommodation for disability during any stage of the volunteer intake process.

The personal information you provide us with on this form is required for you to become a volunteer at Hanover & District Hospital and will be used to communicate with you for volunteer activities. It will be kept confidential. If accepted as a volunteer, your personal information will be shared with Hanover & District Hospital Auxiliary, of which all active volunteers are members.