

# Volunteer Application - Junior

Vegreville Manor



## Contact/General Information

Name		
Street Address		
City		Postal Code
Home Phone		
Work Phone		
Cell Phone		
E-Mail Address		
Birthday (DD/MM/YY)		

## Availability

During which hours are you available for volunteer assignments?

- Weekday mornings       Weekend mornings  
 Weekday afternoons       Weekend afternoons  
 Weekday evenings       Weekend evenings

## Interests

Tell us in which areas you are interested in volunteering

- Recreational Activities       Food Services/Dietary  
 Church Services       Housekeeping/Laundry  
 Out-trips/Shopping       Special Events  
 Crafts with Residents       General Visitation  
 Other (please elaborate)

## Special Skills or Qualifications

Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports. Include languages spoken.

## Previous Volunteer Experience

Summarize your previous volunteer experience.

### Person to Notify in Case of Emergency

Name/Relationship		
Home Phone		Cell Phone

Please provide any additional information that you would like us to consider for your volunteer placement. As well, please include information regarding any specific medical issues, disability, (including physical or intellectual problems), or any health issues you are dealing with should anything occur while you are volunteering with St. Michael's Health Group

### Agreement and Signature

I agree to abide by St. Michael's Health Group's Rules and Regulations and to keep all information confidential. **I understand that a background/police check is required** prior to commencing volunteer work. I know of no medical reason why I cannot volunteer for this organization.

Name (print)		
Signature		Date

### Parental Consent

I allow \_\_\_\_\_ (name of applicant) to volunteer at St. Michael's Vegreville Manor and authorize St. Michael's Health Group to obtain reference information from the persons listed below, under assurance that the information provided will remain confidential.

Name (print)		
Signature		Date

### Reference Authorization

I authorize St. Michael's Health Group to obtain character reference information from the persons listed below under the assurance that the information provided will remain completely confidential.

Name (print)		
Signature		Date

<b>Reference #1</b> Name		
Home Phone		Cell Phone
Relationship		
<b>Reference #2</b> Name		
Home Phone		Cell Phone
Relationship		Cell Phone

### Consent, Authorization & Release (by Parent/Guardian)

I hereby give my consent to St. Michael's Health Group to photograph, videotape or record me and/or my participation in their program activities and/or event. I transfer and release ownership of all such material to St. Michael's Health Group as their exclusive property and as their copyright material to use as they see fit. I understand and agree that I will not ever receive any compensation for the use of such images and/or materials.

Name (print)		
Signature		Date