Volunteer Application - Adult

Long Term Care Centre / Millennium Pavilion

Contact/General Information

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

Availability

When are you available for volunteer assignments?

___ Weekday mornings
___ Weekday afternoons
___ Weekday evenings
___ Weekend mornings
___ Weekend afternoons
___ Weekend evenings

Interests

Tell us which areas you are most interested in volunteering

___ Clerical/Office Work
___ Recreational Activities
___ Church Services/Portering
___ Out-trips/Shopping
___ Crafts with Residents
___ General Visitation
___ Pastoral Care
___ Therapeutics Portering
___ Food Services/Dietary
___ Housekeeping/Laundry
___ Special Events
___ Community Bingos (fundraising)
___ Casino (fundraising)
___ Other (please elaborate)

Special Skills or Qualifications

Please 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		
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

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

Reference #1 Name		
Home Phone		Cell Phone
Relationship		
Reference #2 Name		
Home Phone		Cell Phone
Relationship		

Consent, Authorization & Release

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