LAKERIDGE HEALTH VOLUNTEER RESOURCES

ADULT VOLUNTEER APPLICATION

☐ BOWMANVILLE ☐ OSHAWA ☐ PORT PERRY ☐ WHITBY

PLEASE PRINT

☐ Mr. ☐ Miss
☐ Mrs. ☐ Ms.

_____ Last Name _____ Given Name

Address: _____ Number/Street/Apartment _____ City _____ Postal Code

Telephone: Home: ( )_____ Cell: ( )_____

Email Address: _____

Date of Birth: (optional – for statistical purposes only) ____/____/____ (date/month/year)

Please tell us about yourself:

Current occupation:

Previous work experience:

Experience or training as a volunteer (Groups, Clubs, Organizations etc):

Languages other than English spoken:

☐ Italian ☐ Polish ☐ German ☐ Dutch ☐ Urdu ☐ Farsi
☐ Cantonese ☐ Persian ☐ Tagalog ☐ Other _____

Limitations to your activities:

☐ None ☐ Hearing ☐ Lifting ☐ Walking ☐ Standing
☐ Other: _____

Times Available: ☐ Morning ☐ Afternoon ☐ Evening

Days Available: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Areas within the hospital where you would be interested in volunteering (if known):

1. _____ 2. _____

For Office Use Only

Placement	Date Placed	Day(s)	Time	Review Date

Application Date:	Interview Date:	Orientation Date:

Emergency Contact Information:

Name: _____ Telephone # (daytime): _____

Relationship to you: _____ Email Address: _____

How did you hear about our volunteer program?

What are your reasons for volunteering?

Special Skills: ☐ Committees ☐ Crafts ☐ Computer

☐ Other _____

Please initial indicating you have read and agreed to each of the following 4 items, then sign below:

initial **I authorize my name, address and telephone number(s) to be given to the Auxiliary/Association/Volunteer Services and Corporate office of Lakeridge Health for the means of sharing information and/or assisting with various events (membership is automatic).**

initial **I acknowledge that it is my responsibility to inform Volunteer Resources of any change in my information such as my address or phone number; email address; emergency contact information; change in Criminal Information Record status, etc.**

initial **I acknowledge that it is my responsibility to return any hospital property (I.D. badge; parking transponder, etc.) on the completion of my time as a volunteer**

initial **I am submitting a complete application form (which includes 2 references) and acknowledge that this completed application will be kept on file for 6 months.**

_____ _____

Signature **Date**

Please mail or drop off your completed application (2-page application plus 2 references):

Lakeridge Health
Administrative Office for Volunteer Resources
47 Liberty St. S.
Bowmanville, ON
L1C 2N4

LAKERIDGE HEALTH VOLUNTEER RESOURCES

ADULT REFERENCE FORM (1)

Character Reference for: _____

Reference Name: _____
(excluding family members)

Telephone Number: ( ) _____

1. How do you know this individual and for how long?

2. What personal strengths do you feel this person will bring to the hospital?

3. Can this person be counted on to follow through on the commitments he/she undertakes? Do you have any examples of this?

4. Is there anything that might hinder this person from being an effective volunteer?
   No ❑ Yes ❑ Please elaborate:

5. Would you recommend this person to volunteer with Lakeridge Health?
   Yes ❑ No ❑ Please elaborate:

6. Please add any additional comments you feel would be useful to us in arriving at a decision regarding suitability for becoming a volunteer at Lakeridge Health.

We thank you for your assistance.

_____ _____

Signature: ***Date***

LAKERIDGE HEALTH VOLUNTEER RESOURCES

ADULT REFERENCE FORM (2)

Character Reference for: _____

Reference Name: _____
(excluding family members)

Telephone Number: ( ) _____

1. How do you know this individual and for how long?

2. What personal strengths do you feel this person will bring to the hospital?

3. Can this person be counted on to follow through on the commitments he/she undertakes? Do you have any examples of this?

4. Is there anything that might hinder this person from being an effective volunteer?
   No ❑ Yes ❑ Please elaborate:

5. Would you recommend this person to volunteer with Lakeridge Health?
   Yes ❑ No ❑ Please elaborate:

6. Please add any additional comments you feel would be useful to us in arriving at a decision regarding suitability for becoming a volunteer at Lakeridge Health.

We thank you for your assistance.

_____ _____

Signature: ***Date***

Volunteer Immunization & Surveillance Policy

Healthcare Provider Certification
for Volunteers

Healthcare Provider refers to a licensed Physician, Occupational Health Nurse, or Registered Nurse, active and in good standing with their respective college.
This form is to be used for volunteers and is to be completed by a Healthcare Provider

INFORMATION for the Healthcare Provider:
Under the Ontario Occupational Health and Safety Act, employers must advice workers of the hazards of their work. In a hospital setting, workers are at potential risk of acquiring a communicable disease. In addition, healthcare workers immune status to Measles, Mumps, Rubella, and Varicella is required, per the OMA/OHA guidelines under Regulation 965 of the Public Hospitals Act. They also require that individuals be free from active tuberculosis and participate in baseline skin testing. Annual influenza vaccination is strongly recommended.

To meet policy requirements, all volunteers are requested to have the attached Healthcare Care Provider Certification completed prior to commencing any role at Lakeridge Health. The completed form must be shown in order for a photo identification/security badge to be issued. Failure to do so will make the individual ineligible to volunteer on Lakeridge Health premises.

Mandatory Requirements:

1) Tuberculosis (TB) Status

Volunteers are required to have TB testing performed. This can be arranged **at no charge** at a Lakeridge Health site by the Occupational Health Department as per Hospital policy. Therefore, this should not be included in #2 (below) unless your physician prefers to manage it. This would mean a report on these results must be provided along with the attached document.

2) Immunization Status

It is also necessary for your healthcare provider to know your immune status, either immune or not immune to the highly communicable childhood diseases of mumps, measles, rubella and varicella (chickenpox).

Only laboratory evidence of immunity (blood test resulting in a positive titre) is acceptable for measles, mumps and rubella. For varicella (chickenpox), laboratory evidence of immunity or 2 documented doses of varicella vaccine given at least 4 weeks apart (preferably 6 weeks) is acceptable.

Your immune status (either "immune" or "not immune" as defined above) is only required by Occupational Health in the event of an exposure to disease.

Not mandatory but recommended:

- Tetanus/Diphtheris
- Tdap
- Influenza Vaccine
- Hepatitis B Vaccine

Any costs associated with the completion of this form are the responsibility of the volunteer.

Volunteer Immunization & Surveillance Policy

Healthcare Provider Certification
for Volunteers

Last Name	First Name
Department	Supervisor

Healthcare Provider Certification
This form is to be used for volunteers
(Reminder: TB testing should not be included here, unless your physician prefers to manage it. If so, a report on these results must be provided along with this document.)

I, _____ certify that, _____
Healthcare Provider (PRINT NAME) Volunteer (PRINT NAME)

meets the requirements of the volunteer Immunization and Surveillance Policy as outlined on the reverse (or previous page) of this form. (I.e. their immune status is known- either "immune" or "not immune"). The volunteer's healthcare provider is the keeper of this information.

_____ _____
Healthcare Provider Signature Date

Professional Designation: _____

Address: _____
_____

Phone: _____

Volunteer Consent

In the event of a communicable disease exposure or outbreak I,_____
Volunteer (PRINT NAME)
understand that my immune status must be made available to Occupational Health & Safety Services at Lakeridge Health if requested.

<u>This certification is to be kept in my Lakeridge Health file in the volunteer department.</u>

_____ _____
Volunteer Signature Date: