# New LH Logo Volunteer Resources

# Student Volunteer Application

[ ]  Bowmanville [ ]  Oshawa [ ]  Port Perry [ ]  Whitby
Please contact Volunteer Resources for any assistance required to complete this form.

## Contact Information:

[ ] Ms. [ ] Mr.

Last Name: First Name:

Street Address: Apt. #:

City: Postal Code:

Phone: Email Address:

**AVAILABILITY**

What days and times are you available to volunteer? (Check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| **Day** | **Morning** | **Afternoon** | **Evenings** |
| Monday |  |  |  |
| Tuesday |  |  |  |
| Wednesday |  |  |  |
| Thursday |  |  |  |
| Friday |  |  |  |
| Saturday |  |  |  |
| Sunday |  |  |  |

Why would you like to volunteer at Lakeridge Health?

Two areas within the hospital where you would like to volunteer (if known):

(Visit the student section on www.lakeridgehealth.on.ca for a list of opportunities available to volunteers)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| For Volunteer Resources  | Office Use Only |  |
| --- | --- | --- |
| Application Date | Orientation Date | Interview Date |
| Placement | Days | Time |

## Please tell us about yourself:

Current School:

Experience or training as a volunteer (groups, clubs, organizations, etc.):

## Emergency Contact Information

Last Name: First Name:

Phone: Email address:

Relationship to you:

Please read the following 4 statements, and indicate you have read and agreed to each by initialing each checkbox. Then please sign below:

[ ]  I have attached a copy of my immunization record.

[ ]  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.

[ ]  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.

[ ]  I am submitting a complete application form (4 pages, includes 2 references) and understand this completed application will be kept on file for 6 months.

Student Signature: Date:

### For completion by parent or guardian of student below age of 18 years:

My daughter/son \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is age 15+ and has my permission to participate as a volunteer for Lakeridge Health.

Are there issues to be aware of that should influence the assignment given?

 [ ] No [ ] Yes - if yes, please specify here or contact us, at your convenience \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Please drop off your completed application (4 pages), including 2 references and copy of immunization record) to Volunteer Resources at the hospital of your choice, or mail to:

Lakeridge Health Bowmanville

Administrative Office for Volunteer Resources

47 Liberty St. S. Bowmanville, ON L1C 2N4

|  |  |
| --- | --- |
| Lakeridge_cmyk.eps | **LAKERIDGE HEALTH VOLUNTEER RESOURCES****STUDENT REFERENCE FORM** |

Character Reference for:

Reference Name: (excluding family members)

Telephone Number: ( )

1. How do you know this student and for how long?
2. What personal strengths do you feel this student will bring to the hospital?
3. Can the student be counted on to follow through on the commitments he/she undertakes?

Do you have any examples of this?

1. Would you recommend this student to volunteer with Lakeridge Health?

Yes ❑ No ❑ Please elaborate:

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

*We thank you for your assistance.*

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Lakeridge_cmyk.eps | **LAKERIDGE HEALTH VOLUNTEER RESOURCES****STUDENT REFERENCE FORM** |

Character Reference for:

Reference Name: (excluding family members)

Telephone Number: ( )

1. How do you know this student and for how long?
2. What personal strengths do you feel this student will bring to the hospital?
3. Can the student be counted on to follow through on the commitments he/she undertakes?

Do you have any examples of this?

1. Would you recommend this student to volunteer with Lakeridge Health?

Yes ❑ No ❑ Please elaborate:

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

*We thank you for your assistance.*

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_