Lakeridge Health

Volunteer Resources
Adult Volunteer Application

☐ Bowmanville ☐ Oshawa ☐ Port Perry ☐ Whitby

Contact Information:

☐Mr. ☐Mrs. ☐Miss ☐Ms.

Last Name:_____First Name:_____

Street Address:_____ Apt. #: _____

City:_____Postal Code:_____

Home Phone: _____ Cell Phone: _____

Email Address:

Tell us about yourself

Current Occupation/Previous Work Experience: _____

Experience or training as a volunteer: _____

Limitations to your activities: None ☐ Hearing ☐ Lifting ☐ Walking ☐ Standing

☐Other _____

AVAILABILITY

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

Monday	Morning ☐	Afternoon ☐	Evening ☐
Tuesday	Morning ☐	Afternoon ☐	Evening ☐
Wednesday	Morning ☐	Afternoon ☐	Evening ☐
Thursday	Morning ☐	Afternoon ☐	Evening ☐
Friday	Morning ☐	Afternoon ☐	Evening ☐
Saturday	Morning ☐	Afternoon ☐	Evening ☐
Sunday	Morning ☐	Afternoon ☐	Evening ☐

For Volunteer Resources Office Use Only

Application Date: _____ Orientation Date: _____

Interview Date: _____ Placement: _____

Day: _____ Time: _____

Personal information contained on this form is collected pursuant to the Public Hospitals Act and the Freedom of Information and Protection of Privacy Act (FIPPA), and will be used for the purpose of volunteer selection and placement at LH. We will not share this information otherwise without permission from the applicant/guardian.

Why would you like to volunteer at Lakeridge Health? _____

_____

Two areas within the hospital where you would like to volunteer (if known):
(Check out www.lakeridgehealth.on.ca for a list of roles available at our hospitals.)

1. _____2._____

Emergency Contact Information

Last Name: _____First Name: _____

Phone: _____Email address:

Relationship to you: _____

Please read the following 5 statements, and indicate you have read and agreed to each, by initialing each checkbox and please sign below:

☐ 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).

☐ 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 (which includes 2 references and the Volunteer Immunization Surveillance Policy signed by my Healthcare Provider) I understand this completed application will be kept on file for 6 months.

☐ I understand that I would be entering into an "at pleasure relationship" with Lakeridge Health. Continued involvement in any role is dependent upon the decision of Volunteer Resources staff.

_____ _____

Signature **Date**

Please mail or drop off the 5 pages (references and signed Immunization form) to:

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

   _____

   _____

   _____

5. 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.

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

   _____

   _____

   _____

5. 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.

   Your Signature: _____ Date: _____

Volunteer Immunization & Surveillance Policy

Healthcare Provider Certification
For Volunteers

Please have your Healthcare Provider complete page 2 of this form. *Healthcare Provider refers to a licensed Physician, Registered Nurse Practitioner, Occupational Health Nurse, or Registered Nurse, active and in good standing with their respective college.* Any costs associated with the completion of this form are the responsibility of the volunteer.

When volunteering within a healthcare setting, a higher than usual level of monitoring for the possibility of spreading infectious illnesses exists and is a responsibility taken on by all healthcare workers. Volunteers are part of the "healthcare worker" definition within a hospital setting. As such, volunteers must abide by the regulations described below. These steps help to ensure a safe environment for all patients, visitors, and healthcare workers. These requirements exist even when not volunteering directly with patients. If you have any questions please feel free to contact Occupational Health at 905-576-8711 ext. 3710 Monday to Friday 8:00 am to 4:00pm.

INFORMATION for the Healthcare Provider:
Under the Ontario Occupational Health and Safety Act, employers must advise 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 2-step 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). The TB test needs to be current within 30 days of beginning your volunteer involvement with us. We do not recommend starting TB testing until you are contacted for orientation.

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 measles, mumps, rubella and varicella (chickenpox).
Your immune status is only required by Occupational Health in the event of an exposure to disease.

Evidence of immunity for measles and mumps is:
- laboratory evidence of immunity, **OR**
- documentation of receipt of two doses of measles/mumps-containing vaccine given at least four weeks apart on or after the first birthday

Evidence of immunity to rubella is:
- laboratory evidence of rubella immunity, **OR**
- documented evidence of immunization with live rubella containing vaccine (one dose) on or after their first birthday.

Evidence of immunity to varicella (chickenpox):
-laboratory evidence of immunity, **OR**
-laboratory confirmation of disease, **OR**
- documentation of receipt of 2 doses of varicella vaccine given at least 4 weeks apart (preferably 6 weeks)

Recommended vaccinations (not mandatory):

- Tetanus/Diphtheria, Tdap, Seasonal Influenza Vaccine, Hepatitis B Vaccine

Lakeridge Health

Volunteer Immunization & Surveillance Policy

(to be signed by volunteer **and** his/her Healthcare Provider then returned with application)

Last Name _____ First Name _____

Department: Volunteer Resources

Healthcare Provider Certification

This form is to be used for volunteers

(Reminder: 2-step TB testing should not be included here, unless your Healthcare Provider prefers to manage it. If so, a report on the 2-step 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 promptly 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: _____