HOPE HEALTH SERVICES
VOLUNTEER APPLICATION

- Return the completed application to Hope Health Services, Administration, Fraser Canyon Hospital,1275 – 7th Ave, Hope, BC V0X 1L4. Contact Volunteer Coordinator (604-795-4141,local 612909) or FCH Administration (604 860-7720) for FCH applications/inquiries.
- Ask your referees to return their completed forms to you in sealed envelopes; completed reference forms must accompany your application.
- An annual flu vaccination is required for most volunteer roles.
- A Criminal Record Check is required of all volunteers. Please print the form from the following website to complete. Return this form with your application and references. http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/crime-prevention/criminal-record-check/crr026-vol-consent.pdf
-
- Criminal Record Checks are not accepted from the local RCMP detachment. Please complete the form above.
- When your completed application, including two references, the criminal record clearance, and the TB Screening form is received by Volunteer Resources, you will be contacted for an interview. ***Incomplete applications will not be considered.***

PLEASE PRINT			Date
Surname	Given Name		
Street Address	City	Province	Postal Code
Home Telephone Number: _____ Cell Telephone Number _____		Email Address:	

IN CASE OF EMERGENCY NOTIFY:
Name_____ Relationship: _____

Home Ph#_____Cell#: _____Business#: _____

Are there any physical limitations or health problems that you feel we should be made aware that might affect your volunteer placement?

Please indicate the times you are available to volunteer: Shifts are 1-2 hours within the time frame below

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9am - 12 Morning							
Noon-4pm Afternoon							
4pm -8pm Evening							

PLEASE INDICATE YOUR PREFERENCE (1ST, 2ND, 3RD):

FCH Auxiliary ☐ (Gift Shop,Fundraising Events) Fraser Hope Lodge ☐ (Recreation Activities,Visiting,Music)

Hope Hospice Society ☐ Spiritual Health ☐ Public Health ☐ Older Adult Day Program ☐

List any skills, interests, hobbies and personal experiences and training relevant that would be an asset to your volunteer placement:

Would you be interested in joining the on-call volunteer list, to assist with special events or accompany clients/residents to activities?

Yes ☐ No ☐

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Why do you want to volunteer for Hope Health Services?

Education (highest level completed):

Previous and/or current volunteer experiences:

Do you speak, read or write another language? Yes ☐ No ☐

If so, which one(s)? If yes, would you be willing and comfortable to translate for a client/ resident?

Employment History (list the types of jobs, duties, etc. both present and previous)

_____

_____

We require a commitment of 75 hours of volunteer service from our volunteers. Are you able to fulfill this commitment? This may take 6 months to 1 year, depending on how often you volunteer.

Yes ☐ No ☐ If no, please explain: _____

References that may be contacted. Please indicate an Employment and Character reference: Relatives are not permitted to provide references.
(*Enclosed are forms to give to your references. These should be completed and returned to you in a sealed envelope for you to include with your application.*)

	Name	Address	Relationship	Telephone Number
1.				

_____

	Name	Address	Relationship	Telephone Number
2.				

_____

I authorize Hope Health Services to contact the individuals and/or organizations listed above for the purpose of verifying reference information. I hereby give permission to these individuals and/or organizations to release to Hope Health Services all relevant information requested.

Signature of Applicant _____ Date _____

I hereby certify that the information set forth in this application is true and complete. I understand that omissions or false statements will be considered sufficient cause for rejection of application or discharge. If accepted as a volunteer by Hope Health Services, I agree to adhere to all policies and guidelines related to volunteer service.

_____ _____
(Signature) (Date)

If you are under the age of 19 you must have a parent or legal guardian's signature on this document.

_____ _____
(Name – please print) (Signature)

REFERENCE FORM

AUTHORIZATION TO RELEASE INFORMATION

Name of Applicant, _____, has given permission to Fraser Health (FH) to contact you to obtain information about an application to do volunteer work at Fraser Canyon Hospital. The applicant may be working with vulnerable, older adults who may have cognitive and/or physical challenges.

To Be Completed by Referee: (to be completed by someone other than a family member)

Please comment on each of the following characteristics/skills.

Scale: ***N/A*** ***Poor*** ***Fair*** ***Good*** ***Very Good***

Dependability:		**Problem Solving:**	
Responsibility/ Accountability:		**Organizational/ Prioritizing:**	
Initiative:		**Leadership:**	
Team Player:		**Teaching/Mentoring:**	
Flexibility/Adaptability:		**Verbal & Written:**	
Honesty/Integrity:		**Attendance/Reliability:**	

We would appreciate your comments to the following questions to assist in our evaluation of the applicant.

1. Please describe the applicant's strengths: _____

2. Opportunities for Improvement: _____

3. Most volunteer roles will require that the volunteer interacts with seniors who may be experiencing dementia. Please comment on the applicant's ability to interact with frail, elderly residents.

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Would you recommend this applicant for this position ❑Yes ❑No

This applicant is ❑ Highly Recommended ❑ Recommended

❑ Recommended with Reservations ❑ Not Recommended

Relationship to the Applicant _____

Your Organization: _____

Name (please print) _____Email:: _____

_____ _____
Phone Number Date

Please feel free to provide any additional information that will supplement this reference. If you have any reservations about the ability for this applicant to interact with vulnerable children and/or adults, kindly share your concerns.

_____

_____

_____

(PLEASE HAND THE FORM BACK TO THE APPLICANT SEALED IN THE ENVELOPE PROVIDED BY THE APPLICANT) Kindly sign your initials across the seal.

Thank you for taking the time to provide this reference for Fraser Health.

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REFERENCE FORM

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To Be Completed by Referee: (to be completed by someone other than a family member)

Please comment on each of the following characteristics/skills.

Scale: ***N/A*** ***Poor*** ***Fair*** ***Good*** ***Very Good***

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Responsibility/ Accountability:		**Organizational/ Prioritizing:**	
Initiative:		**Leadership:**	
Team Player:		**Teaching/Mentoring:**	
Flexibility/Adaptability:		**Verbal & Written:**	
Honesty/Integrity:		**Attendance/Reliability:**	

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4. Would you recommend this applicant for this position ❑Yes ❑No

This applicant is ❑ Highly Recommended ❑ Recommended

❑ Recommended with Reservations ❑ Not Recommended

Relationship to the Applicant _____

Your Organization: _____

Name (please print) _____Email: _____

_____ _____
Phone Number Date

Please feel free to provide any additional information that will supplement this reference. If you have any reservations about the ability for this applicant to interact with vulnerable children and/or adults, kindly share your concerns.

_____

_____

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(PLEASE HAND THE FORM BACK TO THE APPLICANT SEALED IN THE ENVELOPE PROVIDED BY THE APPLICANT)

Thank you for taking the time to provide this reference for Fraser Health Shared Services BC