

New Volunteer Applicant <input type="checkbox"/>			Returning Volunteer Applicant <input type="checkbox"/>			Date of last activity: mm/dd/yyyy		
Personal and Contact Information								
First Name:			Last Name:			Male: <input type="checkbox"/> Female: <input type="checkbox"/>		
Apt #:		Address:						
City:			Province:			Postal Code:		
Phone Numbers (H):			(M):			(W):		
Email Address:								
Have you ever been convicted of a criminal offence for which a pardon has not been granted? <input type="checkbox"/> Y <input type="checkbox"/> N								
If Yes, please specify:								
Emergency Contact Information								
First & Last Name:					Relationship to you (optional):			
Phone Numbers (H):			(M):			(W):		
Work Experience								
Name of Organization			Position/Duties			From (mm/yyyy) - To (mm/yyyy)		
Volunteer Experience								
Name of Organization			Position/Duties			From (mm/yyyy) – To (mm/yyyy)		
Education								
Highest Level of Education:						Completed <input type="checkbox"/> In Progress <input type="checkbox"/>		
Name of Institution (Optional):								
Area(s) of Study (If applicable):								

Please read <i>carefully</i> before signed and dating the following:	
<p>The Hanover & District Hospital reserves the right to accept or not accept volunteer applicants. Volunteers are placed according to their interests, skills, suitability, and the needs of the hospital. The Hanover & District Hospital reserves the right to release a volunteer from his/her volunteer position if, in the opinion of the hospital, continuance of the volunteer role could cause detriment to the hospital. I understand that false or incomplete information on this application form may disqualify me from volunteering, or result in my dismissal.</p>	
Applicant Signature:	Date: <i>mm/dd/yyyy</i>

Parental Consent- Under 18	
<p>I certify that I meet the minimum age requirement of 16 years old. Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>Parent/Guardian signature is required for all applicants under the age of 18.</p>	
<p>I give consent for my child _____ to volunteer at the Hanover & District Hospital. I understand that my son/daughter must fulfill all program commitment requirements to receive confirmation of volunteer activity.</p>	
Print Parent/Guardian Name:	
Parent/Guardian Signature:	Date: <i>mm/dd/yyyy</i>

Please return completed application package to:
Hanover & District Hospital
Attention: Human Resources: Volunteers
90 7th Avenue, Hanover, ON N4N 1N1
Phone: 519-364-2341 ext 233 Fax: 519-364-3984 Email: hr@hdhospital.ca

The Hanover & District Hospital is committed to providing accessible employment practices that comply with the Accessibility for Ontarians with Disabilities Act (AODA). Please notify us, if you require accommodation for disability during any stage of the volunteer intake process.

The personal information you provide us with on this form is required for you to become a volunteer at Hanover & District Hospital and will be used to communicate with you for volunteer activities. It will be kept confidential. If accepted as a volunteer, your personal information will be shared with the Hanover & District Hospital Auxiliary, of which all active volunteers are members.