STEVENSON MEMORIAL HOSPITAL
200 FLETCHER Crescent, PO Box 4000
Alliston, Ontario L9R 1W7
www.stevensonhospital.ca
Phone (705) 435-6281 ext 1281
E-mail auxiliary@smhosp.on.ca

STUDENT VOLUNTEER APPLICATION FORM

Applicants will be contacted for an interview at Stevenson Memorial Hospital

**

**** All sections must be complete or the application will not be considered. ****

DATE: _____

NAME: _____ PHONE: _____

ADDRESS: _____ POSTAL CODE: _____

_____

E-MAIL ADDRESS: _____

NAME OF PARENT/GUARDIAN: _____ PHONE: _____

SIGNATURE OF PARENT/GUARDIAN: _____DATE: _____
(required if student applicant is under the age of 18)

SCHOOL ATTENDED: _____

AGE (Must be 15 years or older)_____(please be prepared to provide proof of age)

Please note: Students accepted into our Student Volunteer Program are required to make a one year commitment.

Your availability: Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Sunday [ ]

A commitment to volunteering is as important as a commitment to a paid job. Please consider your choice of day and time carefully. People within the hospital will be depending on you to attend.

Interests: _____

Extra curricular activities: _____

Special skills: (i.e. computers, creativity, music, etc.) _____

_____

Are you currently employed? _____ If yes, where? _____

Are you ever been employed?_____ If yes, where? _____

Are you looking for a job? _____ Anticipated start date: _____

If you are a returning student volunteer, would you be interested in serving as a team leader or acting as a mentor for new student volunteers? Yes [ ] No [ ]

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Under the Public Hospitals Act, all persons working or volunteering in a Health Facility must receive a Mantoux Tuberculosis test prior to serving in the facility. The test is given on the arm and must be read 48 to 72 hours later by the Occupational Health Nurse at Stevenson Memorial Hospital.

I _____ agree to receive a Tuberculin test and will return to have it read.
(student applicant)

SIGNED: _____ DATE: _____
(student applicant)

My (daughter/son) _____has my permission to receive the Tuberculin test.
(print full name)

My (daughter/son) _____has received the test within the last year and proof
(print full name) will be supplied.

NAME OF PARENT/GUARDIAN: _____ PHONE: _____

SIGNATURE OF PARENT/GUARDIAN: _____DATE: _____
(required if student applicant is under the age of 18)

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Reference checks are required for individuals entering the Student Volunteer Program.
References may not be a peer or relative. (e.g. parents or family members)

I authorize the Stevenson Memorial Hospital and Auxiliary to contact my references to determine my suitability for the Student Volunteer Program. I understand that the information will be kept confidential.

SIGNED: _____ DATE: _____
(student applicant)

SIGNATURE OF PARENT/GUARDIAN: _____DATE: _____
(required if student applicant is under the age of 18)

Please have your references complete the following area.

REFERENCE # 1

NAME: _____ ORGANIZATION: _____

PHONE #: _____ E-MAIL: _____

How long have you known this person? _____

Why should this person be considered a good candidate for the SMH Student Volunteer Program?

_____

_____

_____

_____

REFERENCE # 2

NAME: _____ ORGANIZATION: _____

PHONE #: _____ E-MAIL: _____

How long have you known this person? _____

Why should this person be considered a good candidate for the SMH Student Volunteer Program?

_____

_____

_____

_____

STUDENT VOLUNTEER APPLICATION FORM

The Interview Committee for the Student Volunteer Program would like to know why you wish to join the program and how you think you may benefit from being in the hospital setting. Please note that student volunteers are not directly involved in patient care. Attach additional sheets if needed.

I understand that, if chosen for the Student Volunteer Program, I must attend a compulsory orientation session at the hospital before I can begin duties (time and date will be announced). I also understand that the volunteer position is an important one and that I must make every effort to attend as scheduled. If I am not well or a circumstance prevents me from attending as scheduled I will contact my supervisor. I further understand that I will be required to sign a confidentiality agreement during the orientation session.

Completed Student Volunteer applications may be mailed to Stevenson Memorial Hospital Auxiliary or dropped off at the information desk just inside the main entrance.
Applications should be in a sealed envelope marked "Attn President SMH Auxiliary"

SIGNED: _____ DATE: _____
(student applicant)