

VOLUNTEER APPLICATION

Home & Community Care
Home Care Services
Box 2420, 5630 Inlet Avenue
Sechelt, BC V0N 3A0
604-885-8517 Fax: 604-741-0728
SCVOLUNTEER@VCH.CA

VOLUNTEER INFORMATION:

NAME:		PREFERRED FIRST NAME:
ADDRESS:		
EMAIL:		
PHONE HOME:	CELL:	
EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:

(You are not required to answer any questions that you do not feel comfortable with.)

☐ MALE ☐ FEMALE ☐ YOUTH ☐ ADULT ☐ SENIOR (ANSWER THESE IF YOU WISH)

Languages other than English (spoken fluently): _____

Do you have any health restrictions? e.g.: wheelchair accessibility, allergies, recent illness, no lifting ☐ Yes ☐ No

IF SO, PLEASE DESCRIBE: _____

What programs are you interested in volunteering for?

☐ VOLUNTEER DRIVERS ☐ MEALS ON WHEELS DELIVERY ☐ TELEPHONE TREE
☐ Volunteer Income Tax Program

OTHER: _____

HAVE YOU DONE VOLUNTEER WORK BEFORE? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE: _____

HAVE YOU EVER VOLUNTEERED AT A VCH SITE: ☐ YES ☐ NO IF YES, PLEASE INDICATE SITE, POSITION, DATES, ETC. _____

TRAINING / SKILLS / EDUCATION: _____

LIST ANY SPECIAL INTERESTS, HOBBIES OR EXPERIENCES: _____

WHY ARE YOU APPLYING FOR A VOLUNTEER POSITION WITH US, AND WHAT DO YOU EXPECT TO GAIN FROM THIS VOLUNTEER EXPERIENCE? _____

TIME

FLEXIBLE? ☐ Yes ☐ No SPECIFIC TIMES AVAILABLE: _____

HOW LONG CAN YOU COMMIT YOURSELF? ☐ 6 MONTHS ☐ 1 YEAR ☐ ONGOING ☐ OTHER

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VEHICLE INFORMATION: *(if you will be driving for VCH)*

Driver's License # _____ Expiry Date: _____

License Class ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ***Please include photocopy of Drivers License with application.

Driver's License Restrictions: _____

Vehicle Colour, Make, Yea, License Plate: _____

Passenger Capacity: _____ Able to Transport Wheelchairs: ☐ Yes ☐ No

Available to drive: (please indicate those that apply)

☐ Local ☐ North Vancouver ☐ Vancouver ☐ Anywhere in the Lower Mainland

REFERENCES

Please list two references – people you have known for at least 12 months who are not related to you ie. employer, co-worker, teacher, coordinator of volunteers, etc.: .

Please inform your references that they will be contacted.

Name: _____ Email: (preferred) _____

Relationship to you: _____ Phone: _____

Name: _____ Email: (preferred) _____

Relationship to you: _____ Phone: _____

It is required by law that all volunteers must submit to a Criminal Record check.

Do you consent? ☐ Yes ☐ No

Date of completed criminal record check: _____

Signature of Volunteer: _____ Date: _____

Parent/Legal Guardian Consent (for applicants 16-18 years old)

I, _____, give my
child/ward _____

permission to participate in the Volunteer Program at Vancouver Coastal Health.

Signature of Parent/Guardian: _____

Name of Parent/Guardian: _____ Date: _____

How did you hear about volunteering at VCH? ☐ Cable TV ☐ Volunteer Centre ☐ Friend

Advertisement: ☐ Newspaper ☐ Poster ☐ Other: _____

Thank you for applying to volunteer with Vancouver Coastal Health!