



Volunteer Application Form

The Stabler Centre
403 Ontario Street – Unit 2
St. Catharines, ON L2N 1L5
Phone: (905) 984-8766 x 229
Fax: (905) 984-8242
E-mail: ndipasquale@hospiceniagara.ca
Website: www.hospiceniagara.ca

Last Name: _____ First Name: _____

Age of Majority? yes ___ no ___ Title (please circle): Mr., Mrs., Ms., Other _____

Address: _____ Apt: _____

City: _____ Postal Code: _____

Home Phone: () _____ Business Phone: () _____ Ext: _____

Cell Phone: () _____ Fax: () _____

E-mail: _____ Licence Plate Number: _____

Occupation/Employer: _____

In Case of Emergency Notify: _____ Phone: () _____

How did you hear about Hospice Niagara? Referral (friend, volunteer, client) _____

Other: _____

Hobbies/Interests (sports, travel, etc.) _____

Special Skills (languages, computer, handicrafts, professional specialties, etc.) _____

Previous Volunteer Work: _____

Goals/Reasons for Applying: _____

CONTINUED ON PAGE 2 (OVER)

What Volunteer Opportunities Offered at Hospice Niagara Interest You?

- | | |
|---|--|
| <input type="checkbox"/> Visiting Volunteer | <input type="checkbox"/> Day Hospice Companion |
| <input type="checkbox"/> Children’s Bereavement Support Facilitator | <input type="checkbox"/> Office Support |
| <input type="checkbox"/> Adolescent Bereavement Support Facilitator | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Day Hospice Driver | <input type="checkbox"/> Welcome Desk |
| <input type="checkbox"/> Gardening/Housekeeping | <input type="checkbox"/> Resident Care |

Visiting Volunteer Information

The following information is used solely for Volunteer/Client matching. It is helpful to have this information to find suitable volunteers for each client. **Completion of this section is not mandatory. All information is strictly confidential.**

Marital Status: _____ Ethnic Background: _____

Religious Affiliation: _____ Languages other than English: _____

Willing to:

- | | |
|--|--|
| <input type="checkbox"/> See Clients who Smoke | <input type="checkbox"/> Visit Clients of both genders |
| <input type="checkbox"/> See Clients with Pets | <input type="checkbox"/> Transport Clients |
| <input type="checkbox"/> Visit Overnight with Clients who require Constant Support | |

At what times are you available to volunteer?

Weekdays: Mornings ___ Afternoons ___ Evenings ___

Weekends: Mornings ___ Afternoons ___ Evenings ___

Notes: _____

PLEASE PROVIDE THREE REFERENCES

(one personal reference only)

Name, Home and Email Address: (include city, province and postal code)	Relationship to Applicant	Daytime Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

This certifies that this application was completed by me and that all the entries and information on it are true and complete to the best of my knowledge. This authorizes Hospice Niagara to check the references I have provided and to conduct a Niagara Regional Police Check.

Signature

Date

Please sign and date this application form. All information is kept strictly confidential.