Trenton Memorial Hospital Auxiliary Volunteer Application

Name: _____ **Date:** _____
First Name *Initial* *Last Name*

Address: _____
Street No. *Street Name* *Apt / Unit No.*

_____
P.O Box *City / Town* *Postal Code*

My current occupation is: _____ ☐ **Retired** ☐ **Student**

Check if applicable: ☐ Summer Student only **Post Secondary Student Volunteer Commitment:** Due to the time and effort it takes to screen and train volunteers, we encourage you to start the process early if you intend to volunteer in the summer only. It takes approximately 3-4 weeks to go through the screening process.

Sex: ☐ Male ☐ Female

Home Phone #: _____ **Email (H):** _____

Work Phone #: _____ **Email (W):** _____

Best time to call? ☐ A.M. ☐ P.M. **Cell Phone #:** _____

How did you find out about volunteering with the Auxiliary?

_____

_____

What skills or experience might you be able to offer? (Check all that apply):

☐ Knowledge of retail sales
☐ Musical skills (eg: piano) ☐ Sewing, knitting, etc. (list below)
☐ Knowledge and experience in business and management
☐ Experience in governance on Boards and committees
☐ Understanding of fiscal and financial matters
☐ Understanding of legal matters
☐ Knowledge and experience in human resource management

List any additional skills you have: _____

_____

Summary of Employment/Training Background:

_____

_____

Availability: What days of the week and times are you available to volunteer?

_____

Please take a moment to review the many volunteer opportunities available, outlined in the TMH Auxiliary Volunteer Brochure. What are your top two areas of interest?

1. _____ 2. _____

Would you be willing to volunteer in any of the following ways? (Check one):

☐ On the TMHA Board ☐ Help with special events

Comments: _____

I will abide by the rules and regulations of the Trenton Memorial Hospital Auxiliary.

Signature of Volunteer: _____ Date: _____

Reference Check Permission

I, _____, give the TMH Auxiliary permission to contact the 2 references listed below to discuss my suitability as a volunteer within the hospital.

Signature: _____ **Date:** _____

List 2 persons who have knowledge of your character and/or experiences. Your references should be people who know you through different relationships and/or situations. For example: employer (paid or volunteer position), co-worker, teacher, etc. *No family members please.*

Reference #1

Name: _____
First Name *Last Name*

Phone or Email: _____ Cell Phone #: _____

Best time to call? ☐ A.M. ☐ P.M. Relationship to applicant: _____

Reference #2

Name: _____
First Name *Last Name*

Phone or Email: _____ Cell Phone #: _____

Best time to call? ☐ A.M. ☐ P.M. Relationship to applicant: _____

For Office Use Only

Below is an intake checklist for new volunteers. Check each item as the steps are completed.

☐ Occupational Health clearance received
☐ Incident-free police check received
☐ References checked
☐ ID badge issued
☐ Smock
☐ Membership
☐ Placement date _____ with _____
☐ Follow-up one month later
☐ Filed

Revised Feb 2012

Volunteering at Quinte Health Care

Please sign and return this form with your application to the Volunteer Office.

☐ **1. Release and Waiver of Liability:**
I understand that Quinte Health Care Corporation and the four Auxiliaries associated with QHC (Belleville, Trenton, Prince Edward County and North Hastings) disclaims any responsibility for any losses or injuries to me, my family, and/or my property.

In consideration of Quinte Health Care Corporation and the four Auxiliaries associated with QHC, permitting me to volunteer, I hereby accept all risks of loss, injury, or damage to me, my family or my property, and exempt Quinte Health Care and the four Auxiliaries associated with QHC, its directors, officers, agents, employees, management, physicians and any other representatives.

In signing this waiver, I do forever release, covenant to hold harmless, and indemnify Quinte Health Care Corporation and the four Auxiliaries associated with QHC, its directors, officers, agents, employees, management, physicians and any other representatives, from any and all actions, causes of actions, claims, demands, damages, costs, losses, expenses on account of, or in any way arising out of, directly or indirectly, all personal injuries or property damages which I may now or hereafter may have, resulting from my voluntary performance of services.

☐ **2. Accessibility, Confidentiality & Hand Hygiene:**
In addition, I have reviewed and understand the "Making Volunteer Services Accessible" section of the Volunteer Handbook as well as the sections explaining confidentiality and hand hygiene: I agree to abide by these sections.

☐ **3. Photo/Video Consent**
I understand that occasionally photos and/or video may be taken during Auxiliary events and services to promote the good work of the Auxiliary within the hospital and to local media. I give permission to the Auxiliary and QHC to use this material for publishing, advertising, education and public relations purposes.

NAME OF VOLUNTEER (Please Print): _____

Date: _____

Signature of Volunteer (if 18 or Over): _____

Signature of Guardian (if Under 18): _____

Revised June 10, 2013

Occupational Health & Safety Department
Communicable Disease Surveillance Program

VOLUNTEER MEDICAL FORM

Walsh & Associates
Occupational Health Services

Dear Health Care Practitioner:

This patient is interested in volunteering at Quinte Health Care.

NAME _____ **HOME PHONE** (_____) _____

In order to ensure the safety of our patients, the Ontario Hospital Association (OHA) outlines mandatory screening standards for the diseases listed below and compliance is required by all persons carrying out duties in the hospital environment. These standards must be met prior to a person commencing volunteer work at Quinte Health Care.

1. Volunteers Must Have Immunity to:

- **Rubella**
- **Mumps**
- **Measles**
- **Varicella / Zoster (Chicken Pox)**

To meet OHA standards, the following are acceptable as proof of immunity:

a. Documented evidence of immunity from vaccination; OR
b. Laboratory evidence of immunity; OR
c. For Varicella/Zoster only, definite history of the disease.

IMPORTANT:

Please **do not provide** health/medical records or additional notes or information of any kind with this form.

2. Tuberculin Testing:

To meet OHA standards, volunteers must be clear of active Tuberculosis and the following TB screening is required:

a. If your patient's tuberculin status is unknown, has been identified as tuberculin negative in the past or has been given a BCG vaccination in the past, a two-step Mantoux skin test with PPD/5TU must be administered UNLESS he/she has:
- Documented evidence of a prior two-step test, OR
- Documentation of a negative PPD within the 12 months preceding this placement, OR
- Two or more documented PPD at any time but the most recent was more than 12 months preceding this placement,

in which case a single-step test must be given.

b. If your patient has had a positive Mantoux test in the past, he/she must have a chest x-ray within the 12 months preceding this placement instead of a tuberculin skin test.

3. Influenza Shot: It is strongly suggested that volunteers have an influenza shot.

I HEREBY CERTIFY THAT THE ABOVE VOLUNTEER **HAS IMMUNITY TO RUBELLA, MUMPS, MEASLES AND VARICELLA / ZOSTER, AND HAS COMPLETED TB TESTING WITH RESULTS SHOWING THAT HE / SHE IS CLEAR OF ACTIVE TUBERCULOSIS**.

Health Care Practitioner's Name (print): _____

Designation (check one): ☐ Physician ☐ R.N.E.C. ☐ R.N. ☐ R.P.N.

Signature: _____ Date: _____

Address: _____ Telephone: _____

Important Information for Volunteers

- This form can be completed by your health care practitioner or taken to your health unit.

- **This form must be completed in FULL and signed by your health care practitioner** in order for us to process your volunteer file. After receiving your completed application package, a volunteer from the Auxiliary Office will contact you regarding possible volunteer opportunities.

- **Please do not submit medical results, immunization records or notes of any kind with this form.** You are only required to have your health care practitioner sign the bottom of Medical Form that you have immunity to Rubella, Mumps, Measles, Chicken Pox, have had the required TB testing and are clear of active Tuberculosis.

- Please note that because TB testing involves 4 visits to your health care practitioner, it may take several weeks to complete. We encourage you contact your health care practitioner or a health unit as soon as possible.

  Visit 1 – to have your first TB skin test
  Visit 2 – to have your first TB skin test read
  Visit 3 – to have your second TB skin test
  Visit 4 – to have your second TB skin test read

- **To meet the Ontario Hospital Association's screening standards for Measles**, assumption of immunity for persons born before 1970 is NOT acceptable for anyone carrying out duties in the hospital environment.

- If you have any further questions about this form, please contact the Quinte Health Care Volunteer Office at 613-969-7400, ext. 2075.

Thank you for your interest in volunteering with us!