



The Stabler Centre
403 Ontario Street – Unit 2
St. Catharines, ON L2N 1L5
Phone: (905) 984-8766 x 224
Fax: (905) 984-8242
e-mail: volunteer@hospiceniagara.ca
Website: www.hospiceniagara.ca

Volunteer Application Form

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: _____

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"/> Creative Minds "Crafter" | <input type="checkbox"/> Day Hospice Driver |
| <input type="checkbox"/> Gardening/Housekeeping | <input type="checkbox"/> Resident Care |
| <input type="checkbox"/> Bingo | <input type="checkbox"/> Welcome Desk |

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:
 See Clients who Smoke Visit Clients of both genders
 See Clients with Pets Transport Clients
 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 (only one personal reference)		
Name	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.