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: mreid@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: _____ 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?

_____ Visiting Volunteer
_____ Children's Bereavement Support Facilitator
_____ Adolescent Bereavement Support Facilitator
_____ Day Hospice Driver
_____ Gardening/Housekeeping
_____ Kitchen Helper
_____ Day Hospice Companion
_____ Office Support
_____ Special Events
_____ Welcome Desk
_____ 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:

_____ See Clients who Smoke
_____ See Clients with Pets
_____ Visit Overnight with Clients who require Constant Support
_____ Visit Clients of both genders
_____ Transport Clients

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.