VOLUNTEER RESOURCES
VOLUNTEER APPLICATION FORM

Island Health Site: Comox Valley

YOUTH ☐
ADULT ☐

DATE:_____

LEGAL NAME: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐	GENDER: ☐ Male ☐ Female ☐ Other	HOME PHONE:
ALTERNATIVE OR NICKNAME:		CELL PHONE:
ADDRESS:	CITY/PROVINCE:	POSTAL CODE:
DATE OF BIRTH: (dd/mmm/yyyy)		E-MAIL:
IN CASE OF EMERGENCY PLEASE NOTIFY: NAME:	RELATIONSHIP:	PHONE #:

PLEASE GIVE TWO REFERENCES – NO RELATIVES — INCLUDE EMAIL ADDRESSES

NAME:	**RELATIONSHIP:**	**PHONE #:**	**EMAIL:**
NAME:	**RELATIONSHIP:**	**PHONE #:**	**EMAIL:**

ARE YOU EMPLOYED? **Full Time** ☐ **Part time** ☐ **No** ☐ **PLACE OF EMPLOYMENT:** _____

ARE YOU CURRENTLY ATTENDING SCHOOL? Yes ☐ **No** ☐

IF YES, WHAT'S THE NAME OF THE SCHOOL AND PROGRAM? _____

HOW DID YOU HEAR ABOUT OUR VOLUNTEER PROGRAM?
VOLUNTEER EXPERIENCE:
WORK EXPERIENCE:

YOUR SPECIAL SKILLS, INTERESTS, HOBBIES?
LANGUAGES? WRITTEN: **SPOKEN:**
WHY ARE YOU INTERESTED IN VOLUNTEERING?
WHAT KIND OF VOLUNTEER ASSIGNMENT WOULD YOU LIKE?
WILL YOU REQUIRE A PARKING PERMIT? **No** ☐ **Yes** ☐ (if yes please complete the attached form)
LENGTH OF COMMITMENT: **6 Months** ☐ **Longer** ☐

TIME AVAILABILITY: (Please Check)

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNINGS							
AFTERNOON							
EVENINGS							

AUXILIARY MEMBERSHIP

ARE YOU A MEMBER OF A HOSPITAL AUXILIARY? Yes ☐ No ☐
IF NOT, WOULD YOU LIKE A MEMBER OF THE AUXILIARY TO CONTACT YOU WITH FURTHER INFORMATION? Yes ☐ No ☐

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GENERAL HEALTH STATUS

Do you have any conditions/restrictions that would impact your ability to perform your volunteer duties safely? **YES☐ / NO☐**

If yes, please describe: _____

Do you have any illnesses or conditions that could be transmitted to other personnel or patients during the course of your duties? YES☐ /NO☐
If yes, please describe: _____

FLU POLICY: Please note that Island Health's Influenza Policy applies to volunteers. This means that volunteers must be immunized for influenza during onsite clinics or through other sources of vaccine such as Public Health Units, pharmacies or family physicians. If volunteers choose not to or are unable to, they may wear a mask during flu season – approx. December 1 to March 31 annually. Volunteers who have been immunized are asked to inform their Volunteer Administrator of the date of their shot.

TUBERCULOSIS SCREENING

Have you ever had active Tuberculosis? YES☐ /NO☐

Have you been experiencing any of the following symptoms for longer than one month?

Persistent cough: YES☐ / NO☐ Excessive fatigue: YES☐ /NO☐ Unexplained weight loss: YES☐ /NO☐

Coughing up blood: YES☐ / NO☐ Excessive night sweats: YES☐ /NO☐ Persistent fever: YES☐ /NO☐

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE:

You will need to make an appointment with your family physician to rule out a communicable condition (such as active tuberculosis). If a TB scratch/skin test is required you will need to go to the South Island TB Clinic or the nearest Public Health Unit. Inform the unit that you are planning to volunteer at a VIHA Site. The results of your TB screening will need to be documented below and returned to your Manager/Coordinator of Volunteer Resources before you may begin volunteering.

Volunteers who will be volunteering in high risk areas – **ERs, ICUs, Microbiology Lab and Cytology/Histology Lab, Respiratory Therapy, Renal Units and dialysis units, Transplant Units, Respiratory units, Bronchoscopy and residential settings** are recommended to have the scratch/skin test done prior to starting their volunteer assignment.

Please Note: Volunteers who travel to areas of high TB prevalence (e.g. Brazil, China, India, Philippines, Thailand, remote areas in

I WILL RESPECT CONFIDENTIAL INFORMATION AND THE RIGHTS AND DIGNITY OF ALL PATIENTS AND RESIDENTS.
I WILL HONOUR MY COMMITMENT AS A VOLUNTEER AND PROVIDE ADEQUATE NOTICE OF MY ABSENCES.
I WILL ABIDE BY THE POLICIES AND STANDARDS OF THE DEPARTMENT OF VOLUNTEER RESOURCES.

_____ _____
SIGNATURE OF APPLICANT DATE

_____ _____
MANAGER, VOLUNTEER RESOURCES DATE

IF APPLICANT IS A YOUTH (UNDER THE AGE OF 19), PARENTAL CONSENT IS REQUIRED. PLEASE SIGN BELOW:

_____ _____
SIGNATURE OF PARENT OR GUARDIAN NAME (PLEASE PRINT)

_____
DATE

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STATEMENT OF UNDERSTANDING

Please read these next two pages carefully. Your signature at the end indicates you have read, understand and agree to each of the following statements.

I, _____ agree to serve as an Island Health Volunteer, and attend regularly and perform my volunteer service to the best of my ability and according to the guidelines provided by Island Health Department of Volunteer Resources. I will meet the time commitments, or provide adequate notice so that alternative arrangements can be made. I will act at all times as a contributing member of the health care team towards accomplishing the mission of Island Health.

PERMISSION TO PERFORM A BACKGROUND CHECK

I give permission for the VIHA Volunteer Resources Departments to perform a check of my background, which may include:

- criminal record check, including a vulnerable sector check
- driving record
- past employment and/or volunteer history
- personal references
- other persons or sources as is appropriate for the volunteer service(s) in which I have expressed an interest

I understand that information collected during this background check will be limited to that which is appropriate to determining my suitability for the particular types of volunteer service in which I will be involved. I understand that all information collected during the check will be kept confidential.

PERMISSION TO TAKE PHOTOGRAPHS AND TO STORE REGISTRATION or PERSONAL INFORMATION ELECTRONICALLY

I understand that:

- Information collected through registration will be stored electronically and used for management functions by the Volunteer Resources and/or Spiritual Care and/or Auxiliary Departments within Island Health
- All Island Health volunteers will be required to have official Island Health photo identification
- From time to time, pictures may be taken for publicity and display purposes (examples below):

*** Displays * Videos * Local Community Newspapers**

*** Volunteer Resources or Island Health Websites * VIHA publications**

STANDARDS OF CONDUCT, RESPECTFUL WORKPLACE AND ACCEPTABLE USE OF ASSETS POLICIES

These policies have been provided to you and/or can be found on the Island Health website at http://www.viha.ca/volunteer_resources/policies_and_procedures.htm. If you do not have access to a computer, please note you will be given a copy of the policies to read at the interview and/or orientation.

I (print name) _____ hereby acknowledge that I have read and understood the following Island Health's policies: (Separate documents)

- Respectful Workplace Policy
- Island Health Volunteer Resources Standards of Conduct
- Acceptable Use of Assets and Resources Policy

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REQUESTS FOR REFERENCE

Educational institutions and employers recognize the value of volunteer experiences.

I understand that the Freedom of Information and Privacy Protection Act prohibits Island Health from giving references without my written approval**.** I hereby give permission to Island Health's Volunteer Resources Departments to provide references, written and verbal, related to my volunteer service**.** I understand that a reference may only be provided after 60 hours of volunteer service and/or at the discretion of the site's Manager, Volunteer Resources.

INFECTION CONTROL RISKS

I understand that as a volunteer with Island Health there are risks associated with being in a facility and on a unit or ward. As I will be volunteering in a health care setting, these risks include possible exposure to communicable diseases. I will be aware of these risks and as a volunteer keep updated on training and safety procedures that could impact my position. I am aware that I might be asked to have additional testing (e.g. TB) if it is warranted, and vaccinations, (e.g.: Influenza Virus) in order to carry out my duties as a volunteer safely. If I am unsure of a potential risk I will ask my Manager for clarification.

EDUCATIONAL OPPORTUNITIES

You may be offered opportunities to take courses that are part of Island Health's on-line Learning Management System (LMS) offered to volunteers as well as staff. When you use the Course Catalogue Registration System (CCRS) within LMS, Island Health/VCH/PHC/FHA* collects personal information about you, such as your education profile, the date and time you accessed the system and also your grades for any quiz or other assessment. Course managers and your direct supervisor may access your user history to confirm that you achieved a passing grade on any course offered through CCRS. Your personal information is collected and used for the purposes of managing educational opportunities and requirements for your affiliation with Island Health/VCH/PHC/FHA. Island Health/VCH/PHC/FHA collects, uses and shares personal information only in accordance with the BC Freedom of Information and Protection of Privacy Act.

* VCH = Vancouver Coastal Health; PHC = Providence Health Care; FHA = Fraser Health Authority

EMERGENCY AND DISASTER PLANNING

❑ I agree to be included on a contact list in the event of a disaster or emergency to provide assistance during a response. I understand that I may not be contacted, and that I may be able to help without waiting to be contacted.

If you agree to the above, please indicate if you have any disaster management training or experience:

_____

*I understand that my **contact information** may be shared with Island Health staff and other volunteers for purposes related to orientation, training, scheduling and other volunteer management functions.*

I AGREE TO ALL OF THE ABOVE: *(unless otherwise stated on this form)*

Signature: _____ Date: _____/_____/_____
Month Day Year