

SECTION A.					
Personal & Contact Information					
First Name:		Last Name:			
Prof. Title:		Preferred name:		Birthday: You must be 16 years of age or older to volunteer Day _____ Month _____	
Apt #:	Street Address:		City	Prov.	Postal Code
Phone Numbers: Home			Cell	Best time to call:	
Email address:					
Have you ever been convicted of a criminal offence for which a pardon has not been granted? <input type="checkbox"/> Y <input type="checkbox"/> N					
If Yes, please specify:					
Emergency Contact Information					
First & Last Name:			Relationship to you:		
Phone Numbers: H			C	W	
Skills and Experience					
How did you hear about us (circle)? Family / Friend SHS Staff SHS Volunteer SHS Website Other website Other _____					
What do you hope to accomplish/gain from volunteering at Sinai Health System (goals)?					
What do you hope to contribute as a volunteer at Sinai Health System?					
Do you have any special skills that you could use / share when assisting with patients?					
What areas/departments are you interested in volunteering with at Sinai Health System?					
Previous Related Experience?					
Which languages are you fluent in?					

Availability [√]							
Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning							
Afternoon							
Evening							

Months Available [√]					
Jan.	Feb.	March	April	May	June
July	August	Sept.	Oct.	Nov.	Dec.

SECTION B.

Please read *carefully* and check mark each statement before signing and date the following

- The Hospital reserves the right to accept or not accept volunteer applicants. Volunteers are placed according to their interest, skills, suitability, and the needs of the Hospital.
- I certify that I am 16 years old or older.
- I agree to submit two references.
- I agree to submit a record of 4 vaccines and two-step TB test as required by the Ministry of Health.
- The Hospital reserves the right to release a volunteer from his/her volunteer position if, in the opinion of the Hospital, continuance of the volunteer role could cause detriment to the Hospital.
- I understand that if I am accepted as a volunteer, I agree to abide by the policies and guidelines in place at Sinai Health System.
- I agree to a 6 month-1 year commitment.
- I understand that I will be required to attend mandatory training(s) as required.
- I understand that I will be required to satisfactorily serve a probationary period.
- If required, I agree to provide medical confirmation of fitness to resume volunteering.
- I understand that false or incomplete information on this application form may disqualify me from volunteering, or result in my dismissal. I give permission for SHS Volunteer Resources to verify all statements made on this application.
- Sinai Health System is committed to an inclusive and accessible work environment and supports the compliance of the Accessibility for Ontarians with Disabilities Act (AODA). Sinai Health System requests that job and volunteer applicants requiring accommodation inform SHS so that suitable arrangements can be prepared to take into account the applicant's accessibility needs.

Sinai Health System is committed to protecting your privacy. The personal information collected in this form is collected in accordance with the **Employment Standards Act, Occupational Health and Safety Act, and Workplace Safety and Insurance Act (Coop only)** It will be used and maintained by the institution for the intended purpose of screening your application. If you have any questions about the collection, use and disclosure of the personal information provided on this form, please contact **Corporate Privacy Officer and Freedom of Information Coordinator at privacy@mtsina.on.ca or 416-586-4800 ext. 2101.**

Please return completed application to:

SHS - Bridgepoint Hospital, Volunteer Resources 5.142 – 1 Bridgepoint Drive, Toronto, ON, M4M 2B5 e: Volunteering.Assistant@sinahealthsystem.ca t: 416-461-8252 ext. 2076; f: 416-461-9972

Signature of applicant: _____

Date: _____

SECTION C. Reference Form (1)

Please note that references must have known the applicant for a minimum of 6 months in a **professional** (non personal) capacity (for example: supervisor, co-worker, coach, volunteer supervisor). Family, friends, lawyers, and physicians are **not** eligible to be references. References may be contacted for additional information.

Volunteers should return this reference form with completed application.

Volunteer Applicant		
First Name:	Last Name:	
Referee Information		
Name:	Organization:	
Phone:	Occupation / title:	
Email:		
What is your relationship to the volunteer (e.g. employee, teacher, coach)?		
I have known the Applicant for _____ years / _____ months		
Referee Information		
<p><i>Volunteers at Sinai Health System are focused on providing compassionate service and support to vulnerable patients, families and visitors. In your own words, what makes the applicant a suitable candidate for volunteer service in a hospital? Please outline their strengths and areas needing improvement. Feel free to attach a separate page if needed.</i></p>		
Ratings		
Please comment on how well the Applicant exhibits the following characteristics of a good volunteer.		
1 - Very limited proof of skills/behaviours 2 - Limited evidence of skills/behaviours 3 - Acceptable proof of skills/behaviours 4 - Good evidence of skills/behaviours 5 - Superior proof of skills/behaviour U- unable to evaluate		
Competency	Rating	Comments
Initiative		
Maturity		
Reliability / dependability		
Integrity		
Customer / Patient focus		
Communication Skills		
Adaptability to Change		
Problem Solving		
Teamwork		
OVERALL RATING		
Signature and Date		
I understand that any willful misrepresentation made by me in connection with this reference will be sufficient cause for the dismissal of the applicant from Volunteer Resources.		
Signature:	Date:	

SECTION C. Reference Form (2)

Please note that references must have known the applicant for a minimum of 6 months in a **professional** (non personal) capacity (for example: supervisor, co-worker, coach, volunteer supervisor). Family, friends, lawyers, and physicians are **not** eligible to be references. References may be contacted for additional information.

Volunteers should return this reference form with completed application.

Volunteer Applicant		
First Name:	Last Name:	
Referee Information		
Name:	Organization:	
Phone:	Occupation / title:	
Email:		
What is your relationship to the volunteer (e.g. employee, teacher, coach)?		
I have known the Applicant for _____ years / _____ months		
Referee Information		
<p><i>Volunteers at Sinai Health System are focused on providing compassionate service and support to vulnerable patients, families and visitors. In your own words, what makes the applicant a suitable candidate for volunteer service in a hospital? Please outline their strengths and areas needing improvement. Feel free to attach a separate page if needed.</i></p>		
Ratings		
Please comment on how well the Applicant exhibits the following characteristics of a good volunteer.		
1 - Very limited proof of skills/behaviours 2 - Limited evidence of skills/behaviours 3 - Acceptable proof of skills/behaviours 4 - Good evidence of skills/behaviours 5 - Superior proof of skills/behaviour U- unable to evaluate		
Competency	Rating	Comments
Initiative		
Maturity		
Reliability / dependability		
Integrity		
Customer / Patient focus		
Communication Skills		
Adaptability to Change		
Problem Solving		
Teamwork		
OVERALL RATING		
Signature and Date		
I understand that any willful misrepresentation made by me in connection with this reference will be sufficient cause for the dismissal of the applicant from Volunteer Resources.		
Signature:	Date:	