



ST. JOSEPH'S CARE GROUP

VOLUNTEER SERVICES APPLICATION FORM CLIENT AND FAMILY PARTNER POSITION

PLEASE PRINT		Date	
First Name	Last Name	Date of Birth Month Day	
Street Address	City	Province	Postal Code
Home Telephone Number:	Email Address:		
Cell Telephone Number:			
IN EMERGENCY NOTIFY: Name	Relationship	Telephone Numbers Home Cell Business	
If desired, please list your employment history:			
Please list any previous and/or current volunteer experiences:			
If desired, please list the education you have completed:			
Please list any skills, interests, hobbies and personal experiences and training relevant that would be an asset to your volunteer placement:			
Are there any physical limitations or health problems that you feel we should be made aware that might affect your involvement			
Do you speak, read or write another language? Yes <input type="checkbox"/> No <input type="checkbox"/> Which language? _____			
How did you learn about St. Joseph's Care Group Volunteer Services?			

What are your reasons for volunteering for St. Joseph's Care Group?

References that may be contacted. Please indicate a professional and personal reference:
(Enclosed are forms to be sent to references)

1.	Name	Address	Relationship	Phone Number
2.	Name	Address	Relationship	Phone Number

I authorize St. Joseph's Care Group to contact the individuals and/or organizations listed above for the purpose of obtaining reference information. I hereby give permission to these individuals and/or organizations to release to St. Joseph's Care Group all relevant information requested.

Signature of Applicant _____ Date _____

If you are under the age of 16 you must have a parent or legal guardian's signature on this document.

Name of Parent of Guardian (Please Print)

Signature of Parent or Guardian

I hereby certify that the information set forth in this application is true and complete. I understand that omissions or false statements will be considered sufficient cause for rejection of application or discharge. If accepted as a volunteer by St. Joseph's Care Group, I agree to adhere to all policies and procedures of St. Joseph's Care Group.

Signature of Applicant

Date

Please forward your application to:

Client and Community Relations Coordinator
Lakehead Psychiatric Hospital
580 Algoma St. N
Thunder Bay, ON
P7B 5G4
Email: engagement@tbh.net