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: Cell Telephone Number:		Email Address:	
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 ☐ No ☐ 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)

	Name	Address	Relationship	Phone Number
1.				
2.				

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