

**Student Volunteer Service Application
West Lincoln Memorial Hospital
Grimsby, Ontario**



**Return completed form to Auxiliary Office WLMH
or email to studentvolunteers51@gmail.com**

The completed form should include

- (1) all pages in this application
- (2) a copy of the latest report card from school
- (3) a copy of your documentation of immunization records

Name: _____

Address: _____

E-mail _____

Phone Number:(home) _____ (cell) _____

Date of Birth : _____

School _____ Current Grade _____

Volunteer and/ or Work Experience (use a separate sheet if need more space)

Date	Location	Description of Work

Interests, Skills, Hobbies: _____

Clubs(school/community/sports,etc.): _____

Type of volunteer work preferred
Circle your choices

Coffee Shop
Front Lobby

B Ward
Fundraising Events

C Ward

Emergency Contacts -2

Name	Phone Number	Relationship

References (2 Required – not family members)

Name: _____

Name: _____

Address: _____

Address: _____

Phone Number: _____

Phone Number: _____

Email: _____

Email: _____

Relationship to applicant: _____

Relationship to applicant: _____

Contact by phone ___ or email _____

Contact by phone ___ or email _____

Immunization Record - Auxiliary Staff

The hospital must have **documented proof of immunization** for all persons carrying on activities in the hospital. Please complete the following:

Name: _____

Immunization History

Date Received

Tetanus/Diphtheria

Measles/Mumps/Rubella
(only applies to individuals born after 1956)

COVID-19 Vaccination – Dose 1 _____ Type _____

COVID-19 Vaccination – Dose 2 _____ Type _____

Have you had Chickenpox? Yes ___ No ___ Unknown _____

Have you had shingles? Yes ___ No ___ Unknown _____

The following is not mandatory but advisable:

Influenza (Flu Shot) Yes ___ No ___

Date

Signature

Parent and Student Commitment Form

This is a responsible position that requires

- a time commitment of at least 40 hours over the next year.
- 1 or 2 hours/week of volunteer time. School Community Hour Time Sheets require the Student Volunteer Coordinator's signature.
- parents/guardians to commit to their youth arriving for their scheduled times and acting according to the hospital policies.

We hope that you understand the need for a joint commitment of the student, parent/guardian and volunteer program in order to make this a successful experience for everyone involved.

PARENT/GUARDIAN I understand my commitment

Date _____

STUDENT I understand my commitment

Date _____

Parental Consent Form

I am the Parent/ Guardian of _____ who has made application to become a student volunteer at West Lincoln Memorial Hospital, Grimsby. I hereby give my consent and understand that this undertaking requires a high standard of reliability, which can only be achieved by my child if he/she has the complete co-operation of the parent/ guardian. It is my understanding that West Lincoln Memorial Hospital's Liability Insurance covers volunteer workers from personal liability. Volunteers are not covered by workplace insurance through WSIB.

Parent/ Guardian Signature _____

Signature of Applicant _____

West Lincoln Memorial Hospital Grimsby, Ontario

Student Volunteer Rules of Conduct

Student volunteers will strive to conduct themselves at all times in the hospital in a responsible and respectful manner, appropriate to the tradition and valued role of a West Lincoln Memorial Hospital volunteer.

Golden Rules

- Be courteous and respectful to patients, peers, staff, volunteers and the public.
- Keep confidentiality.
- Arrive on time and do your volunteer work to the best of your ability.
- Respect hospital policies, procedures and property.
- Notify your volunteer coordinator whenever you will be absent with 24 hours notice, if possible.

I agree to abide by these rules of conduct:

Student Name _____ Signature _____ Date _____

I have reviewed the Student Volunteer Rules of Conduct:

Parent or Guardian Signature _____ Date _____



WEST LINCOLN MEMORIAL HOSPITAL

CONFIDENTIALITY AGREEMENT

All employees/physicians/volunteers/students/observers and staff from external agencies who have access to confidential information, as defined in the Policy Statement, are required to sign the Confidentiality Agreement. This Agreement acknowledges that any violation of the confidentiality policy will be grounds for disciplinary action, up to and including dismissal.

I understand and agree that in the performance of my duties as:
Volunteer Member of West Lincoln Memorial Hospital Auxiliary

I must hold all information in confidence and I will not disclose confidential information to any person other than those whose direction and control I am under. I understand that misuse, failure to safeguard, or the disclosure of confidential information without appropriate approvals may be cause for disciplinary action up to and including termination of employment/contract/services or loss of privileges or affiliation with West Lincoln Memorial Hospital, reporting to an individual's professional College, and/or civil action/criminal prosecution, and/or fines levied by the Ontario Privacy Commissioner.

I commit to hold in confidence all information about patients, residents, clients, and their families, staff and affiliates, as well as the confidential business information of the organization, which comes to my attention while carrying out my duties as agreed within the organization. I commit to continue to respect and maintain the confidentiality of patients, residents, clients and their families, and staff and affiliates of the organization, as well as the confidential business information of the organization even after my employment/affiliation with the organization ends.

This statement confirms that I have read and understand the Confidentiality Agreement for West Lincoln Memorial Hospital, and I understand the implications of a breach of confidentiality.

Print Name (first & last)

Signature

Date

Witness