



**West Lincoln Memorial Auxiliary
Volunteer Application Cover Sheet**

Home Phone: _____ Cell Phone: _____

Name: _____

Address: _____ City: _____

Postal Code: _____

Email: _____

THIS SECTION FOR OFFICE USE:

Date of 1st Interview _____, 20 ____ Interviewed by: _____

Date of 2nd Interview _____, 20 ____ Interviewed by: _____

Confidentiality Signed: Y / N Vest/Membership Paid: Y / N

Immunization Submitted: Y / N Photo Release Consent Y / N

Photo ID Taken: Y / N Police Record Check: Y / N

Parking Permit: Y / N Terms of Engagement: Y / N

COMMENTS: (e.g. volunteer interests, duties, service)

West Lincoln Memorial Auxiliary

Volunteer Application

Name: _____ Date: _____ 20 _____
Address: _____ Phone (home): _____
City: _____ Phone (cell): _____
Email: _____ Postal Code: _____

In case of emergency, notify the following persons:

Name 1:	Name 2:
Phone:	Phone:
Relationship:	Relationship:

Why are you interested in volunteering with West Lincoln Memorial Auxiliary? Please explain. _____

How did you find out about us (e.g. social media, friend, hospital employee or volunteer, other)? _____

If you were referred by someone, please tell us their name. _____

Aside from English, please indicate any other languages you are fluent in. _____

What special skills, hobbies or talents do you have? _____

What skills, volunteer &/or work experience do you have that may benefit this volunteer experience?

I am available to work (check all that apply):

Days: Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____ Sun _____

Time of day: Mornings _____ Afternoons _____ Evenings _____

Do you have summer time availability? _____

I am interested in volunteering in the following Auxiliary service areas:

Coffee Shop _____ Gift Shop _____ Emergency Dept _____ Admin/Clerical _____

Mail Delivery _____ Lobby Info Desk _____ Lottery Ticket Sales _____

Social Events _____ Wards _____ Therapeutic Rec _____

Do you have any further comments and/or questions that you would like to discuss?

References:

Name 1:	Phone:
Name 2:	Phone:

Note: Police screening requirements will be discussed at interview stage.

Signature

Date

Witness



WEST LINCOLN MEMORIAL HOSPITAL

CONFIDENTIALITY PLEDGE

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:

A Volunteer Member of West Lincoln Memorial 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

The HHS Values-Based Code of Conduct “R E S P E C T”

DESCRIPTION

R esponsibility	Accountable for own actions and outcomes.
E tiquette	Demonstrate civility by being polite and considerate.
S upport	Foster an environment that recognizes the various needs of individuals.
P rofessionalism	Adhere to HHS values and policies, and professional and regulatory standards and practices.
E ducation	Continuously develop and demonstrate behaviour that fosters a positive working and teaching environment.
C ommunication	Use clear and concise language, and appropriate methods for giving direction and providing constructive feedback; remember your body language and tone.
T eamwork	Treat all individuals as valuable members of the team.



WEST LINCOLN MEMORIAL AUXILIARY

PHOTO/VIDEO/RECORDING RELEASE FORM

I hereby give permission to **West Lincoln Memorial Auxiliary (WLMA)** or any person authorized by WLMA to take and produce photographs, videotapes, sound recording of myself; to take or collect and use my photograph, video image, voice recording and/or personal interview for possible use in **WLMA** or **Hamilton Health Sciences-affiliated (HHS)** material such as videos, publications, posters, websites, social media; and by external media such as newspapers, TV news programs, and/or radio programs in connection with activities of WLMA or for promotion, publicizing or explaining WLMA or its activities.

WLMA may use, publish and otherwise deal with images, recordings or information as they see fit.

Volunteer Printed Name

Volunteer Signature



Terms of Engagement: Volunteer

I understand:

- Police screening is required for my role(s) and I will provide the required screening to the WLMA Volunteer Coordinator. The type of screening will be determined at the interview.
- Information in my Volunteer Profile may be shared with the department where I volunteer and will be stored safely by the WLMA Volunteer Coordinator in the Auxiliary Office.
- Volunteers are not paid staff and therefore not covered under the Ontario Workplace Safety and Insurance Act and therefore no claims can be made. Volunteers are covered under HIROC.
- West Lincoln Memorial Auxiliary (WLMA) may, at its sole discretion, re-assign or terminate the services of a volunteer at any time with just cause.
- Patient's medical information is strictly confidential and must never be discussed unnecessarily with others. As a member of WLMA, all information concerning HHS patients, families, visitors and staff will be held in confidence. Disclosure of confidential information shall be subject to disciplinary action up to and including discharge.

I have:

Completed the Volunteer Entry training:

- Confidentiality, Code of Conduct & Service Excellence; Personal Protective Equipment, Safe Work Spaces and Infection Prevention and Control

I will:

- I will follow all health and safety protocols for hand hygiene, universal masking, all precautions and best practices as it relates to reducing the spread of viruses. I will share any health and/or symptom related concerns with the *most responsible person*.
- Participate fully in WLMA/HHS Orientation & Training as required from time to time (i.e.: Sign in/out, Infection Control, Absenteeism Protocol, program-specific, etc.).
- Review the Volunteer Position Description(s) (V.P.D.) and agree to perform all tasks to the best of my ability, without going beyond the boundaries of the role.
- Be punctual and notify program staff of any absences in a timely manner.
- Notify the Auxiliary Office if my contact information changes.
- Return my volunteer uniform, photo I.D. and parking permit card to the Auxiliary office when requesting a leave of absence or resignation. An invoice will be issued if not returned.
- Note: New volunteers must pay a \$25 fee for the volunteer uniform prior to the start of my placement.

I will not:

- Present to volunteering if I am feeling unwell and/or fail screening prior to my shift.
- At any time, I will not share my personal information with patients, their families or visitors, or engage outside of the hospital including social media.
- Give or receive gifts to or from patients or their family members unless approval is received from program staff.
- Have any unauthorized persons accompany me while volunteering.
- Translate medical information.

I have read and agree to adhere to all terms listed in the above formal agreement.

Date	Name	Signature	Site
			WLMH