

# St. Joseph's General Hospital Youth Volunteer Application Package FOR NEW YOUTH VOLUNTEERS 2011-12



Welcome to St. Joseph's Youth Volunteer Program! Volunteering with us is fun and interesting. Become part of our team and make a difference!

- ❖ To be Youth Volunteer, you must be in Grade 8 or higher.
- ❖ Shifts are once weekly Monday - Thursday, 4:00 - 5:30 in acute and residential care.
- ❖ In the Transitional Care Unit, shifts are 4:00-5:30 on Monday-Friday and 2:00-4:00 on Saturday and Sunday.

The program will start on **TUESDAY, OCTOBER 11, 2011.**

## **NOTE**

*Due to the popularity of this program, we may not be able to take everyone who applies.*

### **Checklist**

- 1. Contact Janice at 250-890-3030 or janice.wagemann@sjghcomox.ca to book your place on the interest list and a seat at the orientation on either **September 27** or **September 28** from 6:00 - 8:00.
- 2. Complete the application form, Pledge of Confidentiality and Participation Agreement. **ALL PAGES MUST BE SIGNED BY YOU AND YOUR PARENT OR GUARDIAN.**
- 3. Have the reference form completed by a teacher, counsellor or other adult who knows you well. **Family members aren't acceptable references.**
- 4. Attend the orientation in the hospital cafeteria. Bring
  - ✓ your COMPLETED application package
  - ✓ \$10 for your t-shirt.

*If your application package is complete, at the end of the orientation you will be invited to choose a shift based on your place on the interest list. This means that **students in the September 27 orientation will have first choice of shifts.***

**You will not be able to choose a shift until your application package is complete.**

#### **For More Information**

Pat Allan, Manager, Volunteer Services  
Phone: 250-339-1548  
pat.allan@sjghcomox.ca

Janice Wagemann, Administrative Assistant  
Phone: 250-890-3030  
janice.wagemann@sjghcomox.ca

***Many thanks to St. Joseph's General Hospital Auxiliary for their support of this program.***

# St. Joseph's General Hospital YOUTH VOLUNTEER APPLICATION 2011-12

Date: \_\_\_\_\_

Full Name	
Address	
City	Postal Code
Home Phone	Cell Phone
Email	
School	Grade
Family Physician	Phone
Parent/Guardian Name	
Parent/Guardian Daytime Phone	
Medical Insurance Number	

We require a minimum commitment of 30 hours volunteer service in this program within a six month period. Are you willing and able to make this commitment? Yes\_\_\_ No \_\_\_

Why would you like to be a Youth Volunteer? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
 Signature of Volunteer Applicant

**PARENT/GUARDIAN APPROVAL**

I approve of and consent to my child/dependant participating in St. Joseph's Hospital Youth Volunteer program.

\_\_\_\_\_  
 Signature of Parent/Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please print name



# St. Joseph's General Hospital YOUTH VOLUNTEER PROGRAM

## PLEDGE OF CONFIDENTIALITY

All patients and residents of St. Joseph's General Hospital have a right to privacy regarding their health and personal matters, and all volunteers must respect these rights.

Therefore, I \_\_\_\_\_, understand that the health conditions and all personal affairs of acute care patients and residential care residents are strictly confidential and may not be discussed with or disclosed to any person except in the line of my volunteer services.

I also agree that if I learn any other information of a confidential nature through my volunteering, I will not disclose it to those who have no need to know.

I realize that any breach of this trust may lead to termination of my volunteer role at St. Joseph's General Hospital.

\_\_\_\_\_  
Signature of Volunteer Applicant

\_\_\_\_\_  
Date

## PARENT/GUARDIAN APPROVAL

I, \_\_\_\_\_, parent / guardian of the above-named Applicant agree with and consent to the commitment my child / dependant has made above.

Signature: \_\_\_\_\_  
Parent or Guardian

Date: \_\_\_\_\_

# St. Joseph's General Hospital YOUTH VOLUNTEER PROGRAM

## PARTICIPATION AGREEMENT

Please read this page carefully. Your signature at the bottom of the page indicates that you understand and agree to each of the following.

I, \_\_\_\_\_, commit to the following as a volunteer:  
(Your name)

1. I grant permission to the Volunteer Services Program to take photographs and to store registration or personal information electronically.

I understand that

- information collected at the time of registration will be stored electronically and used for management functions by the Volunteer Services program;
- all volunteers are required to have official photo identification; and,
- from time to time, pictures may be taken and used for publicity and display purposes.

2. I will adhere to St. Joseph's General Hospital Volunteer Services program policies and procedures, including record keeping and confidentiality of patient and resident information.
3. I will perform my volunteer duties to the best of my ability.
4. I will meet my volunteer commitments, or provide adequate notice if I cannot.
5. I will represent St. Joseph's General Hospital to the community in a responsible, positive way.

\_\_\_\_\_  
Signature of Volunteer Applicant

\_\_\_\_\_  
Date

## PARENT/GUARDIAN APPROVAL

I, \_\_\_\_\_, parent / guardian of the above-named Applicant agree with and consent to the commitment my child / dependant has made above.

Signature: \_\_\_\_\_  
Parent or Guardian

Date: \_\_\_\_\_



# St. Joseph's General Hospital YOUTH VOLUNTEER PROGRAM



## PERSONAL REFERENCE FORM

PERSONAL REFERENCE FOR: \_\_\_\_\_  
(Name of Youth Volunteer Applicant)

The above youth has applied to St. Joseph's General Hospital Youth Volunteer Program. Please complete the form based on what you know of the student. This youth cannot be considered for the program until we receive a reference. **Note: this form should not be completed by a family member.**

When the form is complete, please fold it and staple or tape it shut.

1. Please describe the youth in the following areas.

a. Attitude:
b. Ability to get along with others:
c. Dependability:
d. Ability to follow instructions:

2. How long have you known this youth?

3. Additional comments:

THIS APPLICANT IS:     RECOMMENDED                       NOT RECOMMENDED

Your name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Phone \_\_\_\_\_

If you have questions, please contact  
**Pat Allan, Manager, Volunteer Services**, St. Joseph's General Hospital  
2137 Comox Avenue, Comox, B.C. V9M 1P2  
Phone 250-339-1548 Fax: 250-339-1505