



STEVENSON MEMORIAL HOSPITAL
200 FLETCHER Crescent, PO Box 4000
Alliston, Ontario L9R 1W7
www.smhosp.on.ca
Phone (705) 435-6281 ext 1281
E-mail auxiliary@smhosp.on.ca



STUDENT VOLUNTEER APPLICATION FORM

Applicants will be contacted for an interview at Stevenson Memorial Hospital

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**** All sections must be complete or the application will not be considered. ****

DATE: _____

NAME: _____

PHONE: _____

ADDRESS: _____

POSTAL CODE: _____

E-MAIL ADDRESS: _____

NAME OF PARENT/GUARDIAN: _____

PHONE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

(required if student applicant is under the age of 18)

SCHOOL ATTENDED: _____

AGE (Must be 15 years or older) _____ (please be prepared to provide proof of age)

Volunteers are required to present evidence of MMR and Chickenpox vaccinations and take a TB test (arranged through the hospital)

Please note: Students accepted into our Student Volunteer Program are required to make a one-year commitment.

Your availability: Monday [] Tuesday [] Wednesday [] Thursday [] Friday [] Saturday [] Sunday []

A commitment to volunteering is as important as a commitment to a paid job. Please consider your choice of day and time carefully. People within the hospital will be depending on you to attend.

Interests: _____

Extra curricular activities: _____

Special skills: (i.e. computers, creativity, music, etc.) _____

Are you currently employed? _____ If yes, where? _____

Are you ever been employed? _____ If yes, where? _____

Are you looking for a job? _____ Anticipated start date: _____

If you are a returning student volunteer, would you be interested in serving as a team leader or acting as a mentor for new student volunteers? Yes [] No []

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Under the Public Hospitals Act, all persons working or volunteering in a Health Facility must receive a Mantoux Tuberculosis test prior to serving in the facility. The test is given on the arm and must be read 48 to 72 hours later by the Occupational Health Nurse at Stevenson Memorial Hospital.

I _____ agree to receive a Tuberculin test and will return to have it read.
(student applicant)

SIGNED: _____ DATE: _____
(student applicant)

My (daughter/son) _____ has my permission to receive the Tuberculin test.
(print full name)

My (daughter/son) _____ has received the test within the last year and proof
(print full name) will be supplied.

NAME OF PARENT/GUARDIAN: _____ PHONE: _____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(required if student applicant is under the age of 18)

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Reference checks are required for individuals entering the Student Volunteer Program.
References may not be a peer or relative. (e.g. parents or family members)

I authorize the Stevenson Memorial Hospital and Auxiliary to contact my references to determine my suitability for the Student Volunteer Program. I understand that the information will be kept confidential.

SIGNED: _____ DATE: _____
(student applicant)

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____
(required if student applicant is under the age of 18)

Please have your references complete the following area.

REFERENCE # 1

NAME: _____ ORGANIZATION: _____

PHONE #: _____ E-MAIL: _____

How long have you known this person? _____

Why should this person be considered a good candidate for the SMH Student Volunteer Program?

REFERENCE # 2

NAME: _____ ORGANIZATION: _____

PHONE #: _____ E-MAIL: _____

How long have you known this person? _____

Why should this person be considered a good candidate for the SMH Student Volunteer Program?

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Completed Student Volunteer applications may be mailed to: **Stevenson Memorial Hospital Association**

Applications should be in a sealed envelope marked "Attn President SMH Auxiliary"

SIGNED: _____ DATE: _____
(student applicant)