

## Volunteer Application

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Closest Intersection: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ Alternate Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

**What skills do you wish to share? What are you passionate about?**

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**Volunteer positions interested in (please check all that apply):**

- Meals on Wheels Driver/Runner
- Office/Admin/Reception
- IT/Accounts
- Escort seniors to medical appointments & shopping
- Food Programming Assistants
- Home Work Club Tutors
- Hospice- Palliative/Bereavement Support Program Volunteer
- Friendly Visiting
- Adult Day program Assistant
- Elderly Persons Centre Assistant
- Board Member
- Food/Clothing/Furniture Bank Assistant
- Christmas Helper (Seasonal)
- Fundraising Support
- Special Events Volunteer
- 'Action for Neighborhood Change' Volunteer
- Other

**What do you hope to gain with your volunteering at SCHC?**

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**Previous employment and/or volunteer experience:** \_\_\_\_\_

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**Length of commitment:** 3 months \_\_\_\_\_ 6 months \_\_\_\_\_ 1 year \_\_\_\_\_ Other \_\_\_\_\_

**Will you be available at a short notice (Y/N):**

**Do you require any accommodations or additional assistance in the event of an emergency evacuation? If yes, please indicate.**

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**How did you hear about SCHC?**  Our Website  Local newspaper  Our other locations  School  
 Friend/Family  Public Library  Community Centre  Volunteer Toronto  Other

**Please check (√) for your availability for volunteering:**

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

**Have you ever attended any Diversity Training? If yes, when:**  Y  N

**Are you over the age of 18 years:**  Y  N

**Mode of Transportation:**  Own Vehicle  Public Transit

**Which other languages do you speak besides English/French:** \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alternate Telephone: \_\_\_\_\_

**References: (Please do not use relatives)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**Do you have a copy of your recent Police Records Check ?**  Y  N

**If not, do you consent to get one done?**  Y  N

**I consent to have my photograph used by Scarborough Centre for Healthy Communities for promotional purposes:**  Y  N

*Information collected on this authorized form complies with the Privacy Act and Personal Health Information Protection Act. Scarborough Centre for Healthy Communities (SCHC) collects information to assist with program planning, improvement of services, and research. This information is confidential and shall not be used for purposes other than those for which it was collected, nor shall any identifying information be sent externally, except with your expressed consent or as required by law. We encourage you to discuss any questions or concerns you may have with one of our staff.*

*By signing below you are verifying that the information provided is true and complete. You give us permission to obtain personal information from your listed references. You also agree to follow the policies and procedures for volunteers of SCHC . False statements and omissions are grounds to terminate the volunteer relationship.*

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