Centretown Community Health Centre

Centre de santé communautaire du Centre-ville

Please return completed application to:

Volunteer Program Coordinator
Centretown Community Health Centre
420 Cooper Street, Ottawa, ON K2P 2N6
613-233-4443 ext. 2510
VolunteerProgram@centretownchc.org

VOLUNTEER APPLICATION FORM

GENERAL INFORMATION Date: ______________________

Name ____

Address ______ (Street) ____

(City) ____ (Postal Code) _____________

Phone (primary) _________________________(alternate) ____________________________

E-mail ____________________________

LANGUAGES: please identify languages spoken and /or written

Spoken: _________________ Written: ___________________

_________________ ___________________

_________________ ___________________

Current AVAILABILITY: Please indicate with an X your availability for volunteering**.**

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					
Evening					

I am currently:

Employed full-time
Employed part-time
retired
Seeking employment
Self-employed
Other_____________
Homemaker
student

How did you hear about CCHC's Volunteer Program?

CCHC staff/ volunteer/board member
Volunteer Ottawa
Radio/newspaper/tv
CCHC Website
School
Other: ___________________

EMERGENCY CONTACTS

1. Name _______________________ Relationship ___________________________
   Phone _______________________ alt__________________________________

2. Name _______________________ Relationship ____________________________
   Phone _______________________ alt___________________________________

Are you applying for a specific volunteer position or CCHC program?

If yes, please indicate: ____

Why are you interested in volunteering with CCHC?

____

____

Are you volunteering as part of a school or community program that requires you to complete a minimum number of volunteer hours? **□Yes** **□No**

If yes, How many hours? _________________ By what date ? _________________________

Name of school or community program: ____

REFERENCES

Please provide two references, at least one from a supervisor (do not include family members)

3. Name _______________________ Relationship ___________________________
   Phone _______________________ email___________________________________

4. Name _______________________ Relationship ____________________________
   Phone _______________________ email____________________________________

Authorization for collection of personal information

I authorize Centretown Community Health Centre Volunteer Program staff to collect personal information appropriate to the volunteer position applied for concerning my academic background and employment/volunteer history and to verify the character references I have supplied pursuant to the Freedom of Information Act.

□ AGREE

Name: ______________________________ Date _________________________________