



Membership Application Form

Full Name: _____ Date: _____
Last First

Mailing Address Postal Code

Street Address Postal Code

Phone: _____ Cell: _____

Date of Birth (MM-DD-YYYY): _____ Email: _____

Emergency Contact: _____ Relationship _____ Phone _____

Employment Experience: _____

Volunteer Experience: _____

Please check where you wish to volunteer:

1. CHEMAINUS HEALTH CARE CENTRE

- Inservice** – Serving tea to residents of CHC Facility (Monday to Friday, approx. 1-1/2 hours per week)
- Meals on Wheels** – Driving/delivering meals to people's homes (approx. 2 hours per month)

2. THRIFT SHOP: (Please check which days and times you would prefer)

Retail Sales (Working in the store)

- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday

Morning Shift or Afternoon Shift

Warehouse (receiving, sorting or pricing)

- Monday
- Tuesday
- Wednesday
- Thursday
- Saturday

Morning Shift or Afternoon Shift

PLEASE NOTE:

- All members are expected to volunteer at least 6 hours a month.
- You are strongly encouraged to attend our general meetings held six times a year.
- There is a \$10.00 annual membership fee, payable before your first shift. You will be provided with an apron and name tag.

Consent to photograph, film or videotape a Member for non-profit use

I hereby give consent to the Chemainus Health Care Auxiliary to taking photographs, video or audio tapes of me for the following purposes: (please check areas in which you give consent)

- in-shop purposes, such as bulletin boards, displays and sharing information
- promotional materials such as advertisements, newspaper and magazine articles
- internet purposes such as Facebook, or our website

Print Name: _____

Signature: _____ Date: _____

Agreement of Confidentiality/Dignity

All members of the Auxiliary are required to sign a Confidentiality Agreement and respect it. All matters and information of personal nature pertaining to members, patients, or clients that has been gained within the Auxiliary or any of its units must be treated as confidential. Under no circumstances can any information be divulged other than to persons authorized to receive such information in the course of their duties. Under no circumstances will any person volunteering in the Auxiliary use such information gained to his/her advantage. In accordance with By-Law Part 2, Section 6: a person shall cease to be a member of the Auxiliary upon infraction of this policy.

We Reserve The Right To Ask For A Background Check

I give permission for the Chemainus Health Care Auxiliary to perform a check of my background, which may include a police check, and other persons or sources as appropriate for the volunteer service in which I have expressed an interest and that all information collected during the check will be kept confidential.

I have read and understand the above agreements.

Signature: _____ Date: _____

Please supply 2 local references (other than family)

Name: _____ Phone: _____

Name: _____ Phone: _____

After completing this application, please leave it with the **Thrift Shop Manager**. The Membership Chairperson will contact you shortly.

Thank you for your interest in volunteering with our organization!