



VOLUNTEER APPLICATION

Confidential

Family Name: _____ **Given Names:** _____

Age Group: 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+ ☐

Gender: Male ☐ Female ☐

Address: _____

Telephone: Home: _____ **Mobile:** _____

Email Address: _____

Emergency Contact Details:

Name: _____ **Relationship:** _____ **Phone:** _____

What interests you about volunteering at Burnside Hospital?

What do you hope to gain from your volunteering experience?

What experiences and / or talents do you have that you feel would assist you in the volunteer role you are interested in? (Include languages other than English spoken fluently).

Please tell us about your experiences or understanding of volunteering?

What is your area of interest in volunteering?

- ☐ **Ward volunteer** – interaction with patients including; care of flowers, restocking, menu completion, companionship, administrative tasks.
- ☐ **Welcoming and Guiding** (Courtesy Desk) – providing direction to visitors and patients with some administrative tasks i.e. preparing charts and packs, preparing mail-outs, photocopying
- ☐ **Café Otto** – assisting in preparing sandwiches, making coffee
- ☐ **Administrative/clerical** – data entry
- ☐ **Oncology Support** – patient & support comfort, making refreshments, errands, restocking

How often are you prepared to Volunteer for the Hospital? Weekly ☐ Fortnightly ☐

Volunteers must be willing to commit to Burnside Hospital for a minimum of 12 months.

Please indicate the day(s) you will be available & time(s). (tick)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM						
PM						

Would you consider being contacted to relieve from time to time during volunteer absence? Yes ☐ No ☐

A compulsory Orientation and Induction Program is held monthly and must be attended prior to commencement

Are you currently in paid employment? Full-time ☐ Part-time ☐

Or are you: A student ☐ Unemployed ☐ Retired ☐ Currently volunteering ☐

Have you been referred? (e.g. CentreLink/GP/Return to Work SA). Yes ☐ No ☐

If so, by whom – name & contact details:

Do you have any disability or medical condition that would affect your ability to do certain types of tasks or work in certain areas in your volunteering role? Yes ☐ No ☐

If so, provide details:

Please supply the name and contact details of two (2) referees (non-family)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Do you agree to undergo a mandatory Police/Criminal History Check? Yes ☐ No ☐

Please read and sign the following Applications Declaration prior to submission to Burnside Hospital

Applications Declaration

I.....(full legal name)
declare that the information given in this application is true and correct.

- I am prepared to commit myself to the Burnside Hospital Vision Mission and Values.
- I agree that I will be required to obtain a satisfactory National Police Certificate in support of this application.
- I understand and will adhere to the responsibility as a volunteer for Burnside Hospital that I will treat all information in **absolute confidence**.
- I agree to abide by Burnside Hospital's policies and procedures.
- I understand that I am responsible for complying with the relevant State and Federal Equal Opportunity Legislation.
- I will perform and abide within the guidelines stated in the Rights and Obligations of the Volunteer; The Volunteer Code of Ethics
- I agree to undertake all necessary/appropriate training sessions, supervision and performance evaluation as designated by Burnside Hospital.
- I agree as a volunteer to be loyal to Burnside Hospital, respect its place in the community and maintain its credibility and integrity.
- I understand and agree that I will start my role at Burnside Hospital on a 3 month probation period.
- I agree to abide by Burnside Hospital's dress code standards.
- I acknowledge that any false or misleading information may lead to my application being rejected or any subsequent approval revoked.
- I will notify Burnside Hospital if any of my above circumstances change.
- I agree Burnside Hospital reserves the right to refuse my application.

Applicant's Signature _____ Date: _____