PHSS welcomes and encourages applications from people with disabilities. Accommodations are available on request for candidates taking part in all aspects of the selection process.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **General Information** | | | | | | | | |
| Last Name: | | |  | | First Name: |  | | |
| Email: | | |  | | Phone: |  | | |
| Street Address: | | |  | | City: |  | | |
| Province: | | |  | | Postal Code: |  | | |
| Do you have a current and clear Vulnerable Sector Police Check? | | | | | |  | | |
| What is your preferred contact method?  Email  Phone  Text Message | | | | | | | | |
| **Areas of Interest**  *Please rank by preference from 1 (first) to 10 (last)* | | | | | | | | |
|  | Physiotherapy/Exercises | | |  | Personal Care |  | Art/Music | |
|  | Reading/Writing | | |  | Sports/Games |  | Outdoors/Gardening | |
|  | Companionship | | |  | Advocacy Work |  | Events/Fundraising | |
|  | Other (please specify): | | | | | | | |
| **Previous Experience**  *Please share your relevant skills and training (e.g. caregiving, public speaking, coaching, etc.)* | | | | | | | | |
|  | | | | | | | | |
| Can you provide a resume?  Yes  No  Attached | | | | | | | | |
| **Commitment** | | | | | | | | |
|  | 3-6 Months | | |  | 6 Months – 1 Year |  | Ongoing | |
|  | Other (please specify): | | | | | | | |
| **How did you hear about PHSS?**  *Please select all that apply.* | | | | | | | | |
|  | Online Posting | | |  | Friend/Relative |  | Community Event | |
|  | Other (please specify): | | | | | | | |
| **Applicants under the age of 18 must have a parent/guardian complete the following:** | | | | | | | | |
| I am aware of and support my child/legal dependant’s decision to volunteer with PHSS Medical & Complex Care in Community. | | | | | | | | |
| Name: | | |  | | | | | |
| Relation to Applicant: | | |  | | | | | |
| Phone: | | |  | | | | | |
| Signature: | | |  | | | Date: | |  |
| **Acknowledgement & Authorization** | | | | | | | | |
| *Any information received during my volunteer period concerning the personal, financial or other private affairs of the consumer(s) of PHSS will be treated by me in strict confidence and will not be divulged.*  *I also understand that the information that I have provided in this Application to Volunteer will be verified by PHSS. I hereby grant permission to PHSS to contact any persons who might be able to verify the information.*  *The confidential information on this form is collected under the Health Protection and Promotion Act, R.S.O. 1990, c.H.7 and will be maintained on file. This information will be used for volunteer program planning purposes. If you require further information about this collection contact the Community Development Coordinator at (519) 615-0313.* | | | | | | | | |
| Signature: | |  | | | | Date: |  | |

**Please email a completed copy to** [**JessicaC@phsscommunity.com**](mailto:JessicaC@phsscommunity.com)