



# ***VICTORIA GENERAL HOSPITAL***

## **YOUTH VOLUNTEER APPLICATION PACKET**

Petra Slaughter  
Coordinator Volunteer Resources  
1 Hospital Way  
Victoria, B.C.  
V8Z 6R5

Tel: (250) 727-4134  
Fax: (250) 727-4106  
*(Please call if you are faxing)*

Website: [http://www.viha.ca/volunteer\\_resources/](http://www.viha.ca/volunteer_resources/)

## YOUTH VOLUNTEER PROGRAM

The Vancouver Island Health Authority's Youth Volunteer Program opens the door to a world of opportunities for young adults. It is a wonderful learning experience that provides an opportunity for career exploration, a chance to learn new skills, and also to help your community. Thank you for your interest in this worthwhile program.

We require a minimum 60 hour commitment of approximately 2 hours per week. This commitment is specific to this health care site and may require more time than some school requirements. It is your responsibility to be aware of this. A letter of reference will not be issued prior to completion of the 60-hour commitment.

- 1) To become a Youth Volunteer at the Victoria General Hospital, you must be between the ages of fourteen and eighteen and able to volunteer for a two-hour shift once a week on a regular basis.
- 2) Please complete the enclosed *Volunteer Registration Form* and sign the *Statement of Understanding*. You are also required to have your parent or guardian sign the *Acknowledgement Form* and a teacher or school counsellor needs to fill out the *Teacher Reference Form*.
- 3) Upon completion of the *Youth Volunteer Application Packet* please mail it to:

**Petra Slaughter**  
**Coordinator Volunteer Resources**  
**1 Hospital Way**  
**Victoria, B.C.**  
**V8Z 6R5**

After receiving your application you will be contacted by phone to arrange a specific date and time for an interview. If accepted into the program, you will be notified and scheduled for a general orientation and two area orientations; these must be completed before starting any volunteer assignments.

\*If you do not hear back from us after mailing in your application, it means that you have been placed on a waitlist. If this happens, you are required to check in monthly by giving us a phone call. If you do not reach us please leave us a message stating your full name, phone number, and the date you mailed your application. This allows us to know if you are still interested in volunteering at VGH. If we do not hear from you after 6 months your file will be terminated.

- 4) The last step is attending the general hospital orientation and tour, followed by two area orientations to your placement. You will also be provided with a take home training manual and videos where several topics will be covered such as: Confidentiality, Infection Control, Safe Wheelchair Handling, Role of the Volunteer, Safety and Security... etcetera. This training is mandatory and is important so that you feel confident doing your volunteer assignment.

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**If you are an interested, reliable, young woman or man, I welcome the opportunity to hear from you.**

Petra Slaughter, Coordinator  
Volunteer Resources, V.G.H. site  
**Telephone: 727-4134**  
**Website: [http://www.viha.ca/volunteer\\_resources/](http://www.viha.ca/volunteer_resources/)**

**VICTORIA GENERAL HOSPITAL - VOLUNTEER RESOURCES DEPARTMENT  
YOUTH VOLUNTEER REGISTRATION FORM**

NAME: Mr. Mrs. Ms. Miss	PHONE # Home: _____ Cell: _____
ADDRESS: _____	CITY: _____
DATE OF BIRTH: _____	AGE: _____
POSTAL CODE: _____	
E-MAIL: _____	
IN CASE OF EMERGENCY PLEASE NOTIFY: NAME: _____	
PHONE #: _____	

PLEASE GIVE TWO REFERENCES (Personal, Work, or School)

NAME: _____	PHONE #: _____
NAME: _____	PHONE #: _____

ARE YOU EMPLOYED?  FULL-TIME  PART-TIME  NO PLACE OF EMPLOYMENT: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR VOLUNTEER PROGRAM?	
WORK EXPERIENCE:	
VOLUNTEER EXPERIENCE:	
YOUR SPECIAL SKILLS, INTERESTS, HOBBIES?	
LANGUAGES - WRITTEN: _____	SPOKEN: _____
WHY ARE YOU INTERESTED IN VOLUNTEERING?	
WHAT KIND OF VOLUNTEER ASSIGNMENT WOULD YOU LIKE?	
WILL YOU REQUIRE A PARKING PERMIT? YES _____ NO _____	TYPE OF VEHICLE: _____
LICENSE PLATE #: _____	
LENGTH OF COMMITMENT: (Please Circle)	
3 Months	6 Months
Longer	
<input type="checkbox"/> MINIMAL 60 HOUR COMMITMENT	

TIME AVAILABILITY: (Please Check)

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNINGS							
AFTERNOON							
EVENINGS							

YOUTH VOLUNTEER PROGRAM

NAME OF SCHOOL: _____	GRADE: _____
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- I WILL RESPECT CONFIDENTIAL INFORMATION AND THE RIGHTS AND DIGNITY OF ALL PATIENTS AND RESIDENTS.
- I WILL HONOUR MY COMMITMENT AS A VOLUNTEER AND PROVIDE ADEQUATE NOTICE OF MY ABSENCES.
- I WILL ABIDE BY THE POLICIES AND STANDARDS OF THE DEPARTMENT OF VOLUNTEER RESOURCES.

DEPARTMENT USE ONLY
SIGNED CONFIDENTIALITY ACKNOWLEDGEMENT ON FILE: YES <input type="checkbox"/>
AREA: _____
DAYS: _____
TIME: _____
START DATE: _____
ASSIGNMENT: _____

_____ SIGNATURE OF APPLICANT  _____ COORDINATOR OF VOLUNTEER RESOURCES  _____ DATE
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**TUBERCULOSIS SCREENING (Please Circle YES or NO)**

Have you ever had active Tuberculosis? YES / NO

Have you been experiencing any of the following symptoms for longer than one month?

Persistent cough: YES / NO      Excessive fatigue: YES / NO      Unexplained weight loss: YES / NO  
 Coughing up blood: YES / NO      Excessive night sweats: YES / NO      Persistent fever: YES / NO

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE:**  
 You will need to phone the VIHA TB Clinic at 952-4217 to arrange for FREE TB screening. The results of you TB screening will need to be documented below and returned to your Coordinator of Volunteer Resources before you may begin volunteering.

**INFECTION CONTROL DEPARTMENT ONLY:**

TB SKIN TEST/S: DATE \_\_\_\_\_ RESULT \_\_\_\_\_ DATE \_\_\_\_\_ RESULT \_\_\_\_\_

CHEST X-RAY (if required): DATE \_\_\_\_\_  No Evidence of active TB       Needs Further Investigation

Doctor/Nurse Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**GENERAL HEALTH STATUS**

Do you have any medical conditions/restrictions, which would impact your ability to perform your volunteer duties safely? YES / NO  
 If YES please describe:

Do you have any illnesses or conditions that could be transmitted to other personnel or patients during the course of your duties? YES / NO  
 If YES please describe:

**FOR USE BY VOLUNTEER RESOURCES ONLY**

INTERVIEW		FOLLOW UP	
PHOTO ID		REFERENCE CONTACTED	
NAME BADGE		PARKING PERMIT	
TIME SHEET		ASSIGNMENT GUIDE	
CARDEX		AOR ORIENTATION	
UNIFORM		VOR ORIENTATION	

**INTERVIEW NOTES**


**FOLLOW UP NOTES**


**DEPARTURE NOTES**


**TRAINING / IN SERVICES:**

TOPIC:	DATE:
TOPIC:	DATE:
TOPIC:	DATE:



VICTORIA GENERAL HOSPITAL  
VOLUNTEER RESOURCES DEPARTMENT

Re: Application for the Youth Volunteer Program

**TEACHER REFERENCE**

*(To be completed by Teacher, Counsellor or Minister)*

The applicant wishes to be a Youth Volunteer in our hospital. We require a minimum sixty-hour commitment of approximately 2 hours per week. Would you please complete this portion of the application form and have the student call me for an interview. This information must be submitted for the intake process and as Youth Volunteer positions become available.

NAME OF APPLICANT \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING	YES	NO	SEE COMMENT
1. Is the applicant a suitable candidate?			
2. Is the applicant reliable?			
3. Is the applicant considerate of others?			
4. Does the applicant work well with others?			
5. Does the applicant require constant supervision?			
6. Do you feel the applicant's school work would suffer through participation in this program?			

COMMENTS:

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Written Signature \_\_\_\_\_ Position \_\_\_\_\_

Print Signature if above unreadable \_\_\_\_\_ Date \_\_\_\_\_

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VICTORIA GENERAL HOSPITAL  
VOLUNTEER RESOURCES DEPARTMENT

Re: Application for Volunteer Youth Program

**PARENT/GUARDIAN ACKNOWLEDGEMENT**

NAME OF YOUTH: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

NAME OF SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL ADDRESS: \_\_\_\_\_

SCHOOL PHONE NUMBER: \_\_\_\_\_

**PARENT OR GUARDIAN ACKNOWLEDGEMENT**

I am aware that the above student would like to participate in the Volunteer Youth Program at Victoria General Hospital.

- I understand that the Volunteer Resources Department *requires my daughter/son to complete a minimum of 60 hours of volunteer service*, prior to asking for a reference.
- I will ensure all Hospital Items will be returned upon completion of the Volunteer Placement, such as: photo ID, uniform and/or parking permit.
- I give permission for Volunteer Resources to provide references or certificates relating to my daughter's/son's volunteer experience to schools, education institutes, and employers who recognize and value volunteerism.
- I give permission for the VIHA to take photographs and to store registration or personal information electronically of my daughter/son. I understand that:
  - Information collected at the time of registration will be stored electronically and used for management functions by the Volunteer Resources.
  - All VIHA volunteers are required to have official VIHA photo identification

I give permission for pictures to be taken of my daughter/son from time to time for publicity and display purposes:  
(Please check the following boxes)

<input type="checkbox"/> Displays	<input type="checkbox"/> Videos	<input type="checkbox"/> VR or SC Websites	<input type="checkbox"/> VIHA publications (i.e. Gazette)	<input type="checkbox"/> Newspapers
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I give my approval and support for the above student's participation. I will support him/her in attending regularly and encourage him/her to perform their volunteer services according to the guidelines provides during their orientation.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_

PRINTED NAME OF PARENT/GUARDIAN: \_\_\_\_\_

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## VOLUNTEER OPPORTUNITIES CHECKLIST

Please check off all of the volunteer assignments that interest you ✓

### ADULT PROGRAM

- Patient Support Visiting and Special Request Volunteer  
 Visiting and leisure activities take place on various units:
  - Gastrointestinal
  - Short Stay Surgery
  - Outpatient Rehab
  - Neurosciences
  - Urology
  - Respiratory
  - General Medicine
  - Geriatric Rehab
  - Gynecology
  - Neurological
  - Sub Acute Seniors
  - Orthopedics
- Auxiliary Membership / Position
- Emergency
- Entertainment
- Garden, Plant & Flower Care Volunteer
- Just Art (1:1 bedside or small groups)
- Community Knitters / Sewers / Crotchet Volunteers
- Library Cart Book and Magazine Service
- Library Volunteer Organizer
- Medical Genetics Program Projects - Student Volunteer
- Monthly Book Sales
- Medical Imaging
- Mammography (Females Only)
- Office (helper/ assistant)
- Recruitment and Intake Volunteer
- Volunteer Orientation Leader
- Volunteer Presenter
- Patient Pre-Admission Clinic
- PARTY Program (Preventing Alcohol and Risk Related Trauma in Youth)
- Pet Visiting (occasional):
  - PATS members of Pacific Animal Therapy Society and approved by VGH - VIHA
- Child Life Volunteer
- Child Life: Surgical Daycare
- Child Life: Special Care Nursery/Neonatal (on call)
- Leisure / Activity Volunteer
- Red Cross Loan Depot Organizer (in coalition with ER)

### We also have an extensive **YOUTH PROGRAM**

- This program runs September to June (with some exceptions during the summer months)
- Do you know any Youth between the ages of 14 and 18 who may be interested?

- Patient Support Volunteer
- Auxiliary Summer Program (July - August)
- Special Request Volunteer
- Summer Garden Volunteer
- Library Cart
- Office Helper
- Hymn Sing
- Toy Cleaning