



APPLICATION FORM FOR VOLUNTEERS

SURNAME (Mr/Mrs/Miss/Ms).....

FIRST NAME(S).....

ADDRESS.....

.....Postal code

TELEPHONE NO. (Home) (Work) (Mobile)

EMAIL ADDRESS

NAME & TELEPHONE NO IN CASE OF AN EMERGENCY.....

DATE OF BIRTH OCCUPATION (If any).....

PREVIOUS WORK EXPERIENCE

HAVE YOU ANY HEALTH PROBLEMS* YES/NO

(*which could affect your performance as a volunteer)

HAVE YOU ANY ALLERGIES (i.e. food, latex, etc.) YES/NO

ARE YOU ON ANY MEDICATION* YES/NO

(*which could affect your performance as a volunteer)

ARE YOU A CAR OWNER YES/NO

PLEASE GIVE DETAILS OF ANY OTHER CURRENT VOLUNTARY OR COMMUNITY WORK YOU

UNDERTAKE

INTERESTS/ SKILLS/ HOBBIES.....

HAVE YOU ANY PARTICULAR INTEREST, EXPERIENCE OR QUALIFICATIONS WHICH MIGHT BE

USEFUL AT LES BOURGS

.....

.....

.....PTO

PLEASE PLACE A TICK BY THE AREAS OF VOLUNTARY WORK WITHIN LES BOURGS WHICH INTEREST YOU (you may tick as many as you want)

- | | |
|--|---|
| <input type="checkbox"/> SUPPERS (Light Meals) | <input type="checkbox"/> RETAIL - ST MARTINS MAIN SHOP |
| <input type="checkbox"/> RECEPTION | <input type="checkbox"/> RETAIL - ST MARTINS CHILDRENS SHOP |
| <input type="checkbox"/> IN-PATIENT UNIT (following 1 yrs service) | <input type="checkbox"/> FUNDRAISING |

TIME AVAILABLE {Approximately} (please tick as appropriate with approx. hours)

	MON	TUES	WED	THURS	FRI	SAT	SUN
Morning
Afternoon
Evening

NAME & ADDRESS OF TWO PEOPLE WHO MAY BE CONTACTED FOR A REFERENCE

.....

.....

.....

TEL NO TEL NO.....

DATA PROTECTION – Access to the information will be restricted to a limited number of authorised Les Bourgs Hospice staff. The information may also be used for the purpose of compiling employee statistics and equal opportunities monitoring. I give my consent to this information being processed and stored (by means of a computer database or otherwise) as described above, for the duration of my voluntary work to fulfil the statutory, or recommended, retention periods when I am no longer a volunteer of Les Bourgs Hospice.

I confirm that all the information given on this form is complete and correct by signing below.

SIGNED..... DATE.....

Volunteers are appointed following a trial period of approximately 8 weeks.

I agree that the hospice can keep my details in a computer generated file. This information is for the hospice use only and will not be shared outside of the hospice.

PLEASE COMPLETE AND RETURN THIS FORM TO: MRS LARA HIGGINS, LES BOURGS HOSPICE, ANDREW MITCHELL HOUSE, RUE DU TERTRE, ST ANDREWS, GY6 8SF.