475 Guildford Way,
Port Moody, B. C. V3H W9
Gift Shop Phone: 604-461-2022

TEEN VOLUNTEER APPLICATION FORM 16-18 YEARS OF AGE

Personal Information:

Last Name:____________________ First Name:____________________ Date of Birth(MM/DD/YYYY)________________

Address____

City:____ Postal Code:____

Telephone:___________________ Cell Phone:__________________________ E-Mail:_______________________________

Eagle Ridge Hospital Auxiliary Requirements:

Eagle Ridge Hospital Auxiliary is a 100% volunteer based fundraising organization and is a registered charity that encourages the following contributions from every member: honesty, integrity, reliability, punctuality, accountability, cleanliness, tidiness, respect of self and others, cheerful and willing attitude, willingness to have a good time within these guidelines and smiles, smiles, smiles.
A minimum of 6 volunteer hours per month are mandatory to maintain active membership.

GIFT SHOP TEAM, WEEKEND COFFEE PROGRAM, ERHA THRIFT SHOP, (BAKING/KNITTING/CROCHET/CRAFT/USED BOOK ORGANIZER/HANDLER)

Why are you interested in volunteering with Eagle Ridge Hospital Auxiliary and what areas are of interest to you?

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Interests and Abilities:

List any hobbies, skills, interests and experiences you wish to share with us and also what career direction you are planning at this time:

____

____

____

Teacher Recommendations: How well does this applicant demonstrate the above requirements?

Teacher Name: ____Email:______________________________________

Comments: ____

Teacher Name: ____Email:______________________________________

Comments: ____

Parent/Legal Guardian Consent:

I,____________________________________ *(Print your name)* grant my child,___________________________*(Print applicant's name)*

permission to participate with a volunteer Team with Eagle Ridge Hospital Auxiliary.

Date:(MM/DD/YYYY)_____________________ Signature of Parent/Guardian:_____________________________________

Tel:*(In case of emergency)*_______________________

*Do you have any health issues we should be made aware of?*____

Signature of Applicant:_______________________________ Date:(MM/DD/YYYY)______________________________

EAGLE RIDGE HOSPITAL AUXILIARY – "Notification for Collection of Personal information":

In accordance with the Personal Information Protection Act of B. C. (hereafter referred to as the "Act"), any personal information collected or requested on this membership application form will be used by Eagle Ridge Hospital Auxiliary (hereafter referred to as the "Auxiliary") only for the purposes of:

a) Maintaining a list of members of the Auxiliary as required by the Societies Act
b) Maintaining a mail and/or email distribution list for the purpose of communicating Auxiliary activities.
c) Maintaining a membership list to be given out to executive and volunteer position holders of the Auxiliary, and to other members of the Auxiliary as deemed reasonable and/or necessary by the Membership Convenor.

Personal information collected will not be disclosed to any Auxiliary member or third party without consent.
By completing and returning this membership application form and giving your written signature below, you are consenting to the collection of the personal information in this form for the purposes described above.

____
Signature

I consent to the use of my **name and/or photos** of myself in any Auxiliary publications or advertising.

____
Signature