

Please **PRINT** and **FAX 09 - 375-7065** or **POST** Application to:

ADHB Volunteer Centre
Private Bag 92-024
Auckland 1

Personal Details					
Surname:					
First Names:					
Home Address:					
Telephone No.:	Daytime				
	Evenings/Weekends				
	Mobile				
E-mail address:					
Emergency Contact Name and Telephone No.:					
Date of Birth: (optional to be used for birthdays)					(dd/mm/yy)
Availability					
	Mon	Tues	Wed	Thurs	Fri
Morning 9.00 to 12.30 pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon 12.30 pm to 4.00 pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening 4.00 pm to 7.30pm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maximum number of shifts per week:					
(Please note Greenlane shifts are 8am to 12noon and 12-4pm)					
If the times above do not suit you, please specify your preference:					

Please tick preferred location					
Auckland City Hospital	<input type="checkbox"/>	Greenlane Clinical Centre	<input type="checkbox"/>	or both	<input type="checkbox"/>

Interests and Experience

Why are you interested in becoming a volunteer at Auckland District Health Board?

Previous Work Experience:

Special interests, hobbies and memberships:

List other volunteer experience:

List any languages spoken other than English:

Health

Do you have any special health requirements eg. medication you need to have in an emergency ADHB should be aware of

Yes No

If yes, please list details:

Referees

The Auckland District Health Board is committed to the protection of our patients. Their interests and welfare are paramount. Please give the names of two people we may contact who have known you for more than one year. We may contact these people to ask whether they have ever had any reason to be concerned about your ability to work with patients and their families in a responsible and appropriate manner.

Do we have your permission to contact your referees? Yes No

Name:

Address:

Telephone No.: Business Home

Capacity in which you are known to this person:

Name:

Address:

Telephone No.: Business Home

Capacity in which you are known to this person:

Have you ever been convicted of a criminal offence, or current action pending that could result in a criminal offence?

Yes No

If yes, what does this relate to?

Do we have your permission to publish your name and phone number(s) on the Volunteer-Site Ambassadors Phone List

Yes No

I understand that I will receive training on the ADHB Volunteer Programme.

I understand that I will be required to agree to abide by the organisation's policies.

I understand that all successful applicants are required to have security clearance before being accepted for a volunteer programme.

I declare that to the best of my knowledge the answers in this application are correct and I understand that if any false or deliberately misleading information is given, or any material fact suppressed, I will not be accepted, or if I have already commenced, I accept that my services may no longer be required.

Signed: _____ **Date:** _____

All information given on this form will be absolutely confidential to Auckland District Health Board.