



DEEP RIVER &
DISTRICT HEALTH

Auxiliary

Deep River & District Health Auxiliary

Membership Application

Name: (Please Print) _____

Full Address: _____

Town: _____ Postal Code: _____

Phone No: Home: _____ Business/Cell: _____

Email: _____

Police Check is required for Whistle Stop or Gift Shop

Note – A letter is required from the President of the DRDH Auxiliary for the police check, otherwise there is a charge.

Please check the area and the activities you are interested in:

Retail – Whistle Stop	
Sorting items in the Whistle Stop	
Working the desk in the Whistle Stop	
Would you work as a spare	
Preferred day(s) to work at Whistle Stop	
How often per month	
Retail – Gift Shop	
Working shifts in the Gift Shop	
Would you be on the spare list	
Preferred hours of work –morning – afternoon or evening	

NOTE – All applicants will be on a THREE MONTH probation period.

Signature of Applicant

Date



Deep River & District Health Auxiliary

Statement of Confidentiality

I, the undersigned, do willingly promise to hold in the strictest of confidence any information about a patient, resident, their family, staff member, member of the medical staff, other volunteer, or the organization that is learned while serving as a volunteer for the DRDH Auxiliary. I will make no reference to the identity of any patient, their admission to the hospital, records, diagnosis or treatment. I will not discuss unnecessarily with other volunteers, staff members, patients, or persons within or outside the organization any information I have acquired as a volunteer. Furthermore, I will use in a responsible manner, information gained in the course of my service at the Deep River & District Health.

I understand that such compliance is an on-going condition of volunteering and that any non-compliance with the said policy may result in determining me ineligible for future volunteering.

Signature of Volunteer

Date

Reference Release Authorization

I, _____ hereby authorize the following references to release information regarding my appropriateness to serve as a volunteer with the Deep River & District Health Auxiliary.

I release listed references from all liability arising from release of information.

	Name	Telephone Number
1.	_____	_____
2.	_____	_____
3.	_____	_____