Auxiliary to the Cowichan District Hospital
MEMBERSHIP APPLICATION

NAME:

_____

Last First

ADDRESS:

_____

Number Street City Postal Code

PHONE: _____ **CELL:** _____

EMAIL: _____

MONTH OF BIRTH _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:**_____

PHONE: _____ **CELL:** _____

Please give two personal references (other than family)

NAME: _____ PHONE: _____

Email: _____

NAME: _____ PHONE: _____

Email: _____

How did you learn about the Auxiliary? _____

Do you have a second language? If so, what is it? _____

Please list any special skills, and/or hobbies – typing, computer skills, crafts, etc.

_____

Confidentiality and background check:

1. I give permission for the Auxiliary/Island Health (VIHA) to perform a reference check and understand that information collected during this background check will be limited to that which is appropriate to determining my suitability for the particular type of volunteer services in which I will be involved. I understand that all information collected during the check will be kept confidential.

2. I acknowledge and understand this form to be an application for membership in the Auxiliary to the Cowichan District Hospital. I understand there are Monthly General Meetings (except July, August & December) on the 4th Monday of the month and an Annual General Meeting in April, to which members are encouraged to attend & participate in the decision making to ensure that the Auxiliary's goals are achieved.

3. I understand that to be a Member of the Auxiliary, I am required to pay annual dues, participate in the Auxiliary Welcome, wear photo ID, a smock or name tag as required within the volunteer service area and abide by the confidentiality policy of the facility in which I may be volunteering.

4. I give permission to the Auxiliary/Island Health (VIHA) to take photographs and to store registration or personal information electronically.

5. I give permission for my contact information, name address, telephone and/or cell phone number(s) and email address, to be shared with the Auxiliary membership.

Signature: _____

Date: _____

COSTS
Please make cheques payable to the Auxiliary to the Cowichan District Hospital

Dues $10.00

DUES PAID _____/_____/_____

AUXILIARY TO COWICHAN DISTRICT HOSPITAL

NAME _____

Please tick services that are of interest to you.
You are expected to commit to work a minimum of one shift per month and assist with fund-raising projects.

FUNDRAISING

_____ Gift Shop — Sell merchandise to staff & visitors at the shop located in the Cowichan District Hospital. Gift shop hours are Monday to Saturday, including Stat Holidays. Buyers and stockers are also needed.

_____ Thrift Store — Assist with the operation of the Hospital Thrift Store located at 79 Station St., Duncan. Help with sorting and sales.

_____ Needlers — Items sold in the gift shop, Christmas Chaos and gifts for Cairnsmore

_____ Craft Fairs — We participate at Christmas Chaos

SERVICES

_____ Baby Layettes — Baby layettes for parents in need.

_____ Santa Project — Christmas gifts for patients without relatives.

_____ Baby Toques — Members knit toques which are given to all newborns.

_____ Cairnsmore Place — Serve refreshments to residents & visitors & work in the Stop N Shop

_____ Youth Volunteers — Work with the convener (s) assist with training, scheduling and supervision of 13 to 18 year olds

_____ Grooming Kits — Personal items provided to those admitted to CDH without personal toiletries.

_____ Tray Favours — Favours are crafted to decorate patient food trays celebrating special days each month.

_____ Surgical Sponges — Purchase, label & distribute spongers to the surgical nurse as needed by patients.

Revised: October 2022