The Gabriola Auxiliary for Island Health Care Society
Membership Application

Last Name_____First Name_____

Mailing Address_____Gabriola, BC V0R_____

Street Address_____Gabriola, BC V0R_____

Phone: (home)_____Cell: (or other) _____

Date of Birth (optional)_____ Email: _____

Emergency Contact:_____Relationship:_____Phone: _____

Volunteer Experience: _____

Employment Experience:_____(optional)

Special Skills or hobbies (ex. Sewing, arts, crafts, gardening, electronics, grant writer)

_____

You are encouraged to attend meetings. All members are expected to volunteer at least 4 hours a month.
Membership Dues of $12 annually are to be paid by January 1st.
Dues are for calendar year and are not prorated.

Breakdown of current dues: BCAHA $6.00, Vancouver Island Area Rep $2.00 Auxiliary Education $4.00

Please check the areas that interest you.

_____**Bookkeeper**_____**, Proposal Writer**_____**, Publicity** _____

_____**Ice Cream Scooper** – mornings; or afternoons only_____both subject to Cart/Store times

_____**Events Planner:** What other types of events have you organized: _____

_____**Events worker:** Set up_____Décor_____Kitchen_____Clean up_____Other _____

_____**The Gabe Cart** - **Cook** for Special Events, if so, **do you have a Food Safe Certificate?** _____

_____**The Gabe Shop**: Pricing, sorting or repair _____Décor Cashier_____**Coordinator of** Volunteers.
Preferred: morning shift: 10:45am-2pm_____or 1pm-4pm_____, if so, which day _____
Weekly:_____or occasionally _____

_____**Other Services – Meal on Wheels Driver**_____**Drivers to Doctors**_____
Lifeline installer_____

Agreement of Confidentiality/Dignity

All members of the Auxiliary are required to sign a Confidentiality Agreement and respect it.

All matters and information of a personal nature pertaining to members, patients, or clients/donors that has been gained within the Auxiliary or any of its units must be treated as confidential. Under no circumstances can any information be divulged other than to persons authorized to receive such information in the course of their duties. Under no circumstances will any person volunteering in the Auxiliary use such information gained to his/her own advantage.

In accordance with Society # NR 3909639 a person shall cease to be a member upon infraction.

I have read and understand the above agreement.

Date:_____ Signature: _____

WE RESERVE THE RIGHT TO ASK FOR A BACKGROUND CHECK

I give permission for the Gabriola Auxiliary for Island Health Care Society to perform a check of my background, which will include a police check. All information collected during the check will be kept confidential.

Date:_____ Signature: _____

Please supply 3 local references (other than family)

1) Name_____ Phone _____

2) Name_____ Phone _____

3) Name_____ Phone _____

After filling out this application please leave it with an Auxiliary member. The Volunteer Coordinator, will contact you shortly. Thank you for your interest in our organization.

Gabriola Auxiliary for Island Health Care Society – Executive

Revised 2015