

VOLUNTEER SERVICES APPLICATION

PRÉNOMS:

NOM:

Date of birth : __/ __ /__ yr/mth/day)

ADRESS :

Cell : () _____ - _____
TÉL.: home.: () _____ - _____
Work : () _____ - _____

Postal code :

E MAIL : @

LANGUAGES SPOKEN: French English others: _____

DO YOU HAVE A CAR: YES NO

WORK EXPERIENCE: _____

RELATED PERSONAL EXPERIENCE: _____

EDUCATION/TRAINING: _____

OTHER AREAS OF EXPERTISE/KNOWLEDGE (computers, fundraising, etc.):

HOW WERE YOU REFERRED TO MAISON D'HERELLE?

DO YOU KNOW ANYONE RELATED TO MAISON D'HERELLE (resident, volunteer, staff, visitor, etc...)? Please specify:

LEVEL OF KNOWLEDGE OF HIV/AIDS (1 = low, 10 = high)

Transmission:___ Symptoms and illnesses associated:___ Psychological impact:___

HAVE YOU EVER WORKED ON A VOLUNTEER BASIS: YES NO

What type of work? _____

What did you gain from it? _____

WHY WOULD YOU LIKE TO BECOME A VOLUNTEER AT MAISON D'HERELLE?

WHAT TYPE OF VOLUNTEER SERVICES WOULD YOU LIKE TO DO?

PLEASE CHECK THE TIME FRAMES AMONG WHICH WE COULD SELECT A REGULAR TIME AVAILABILITY:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Day :	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Evening:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night :	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ALTHOUGH THIS WOULD NOT PREVENT YOU FROM WORKING AS A VOLUNTEER, IN ORDER TO BETTER SUPPORT YOU, WE WOULD LIKE TO KNOW IF THERE IS ANYTHING THAT WE MIGHT CONSIDER COULD LIMIT YOUR PHYSICAL OR PSYCHOLOGICAL ABILITIES: medications, HIV positive, contagious diseases, prior psychiatric problems, physical handicap, current personal difficulties, bereavement (less than 5 years), etc. Please specify, or indicate "no":

PLEASE PROVIDE REFERENCE (OTHER THAN FRIENDS OR FAMILY MEMBERS)? INDICATE IF WE CAN TELL THEM THAT WE ARE A HOME LIVING FOR PEOPLE WITH AIDS?

Yes No

Name:_____ Connection:_____ Tel.:()__ -__

Name:_____ Connection:_____ Tel.:()__ -__

CONTACT IN CASE OF EMERGENCY:

Name:_____ Connection:_____ Tel.:()__ -__

NEEDS FOR VOLUNTEER SERVICES AT MAISON D'HERELLE

Please indicate the areas of interest by circling a letter:

V=VERY MUCH

M=MODERATELY

S=SLIGHTLY

N=NOT AT ALL

V M S N Counselling, psychological support

V M S N Hygiene and physical care with the residents

V M S N On call when the workers are overworked: please check accordingly
O Days (week) O Evenings (week) O Nights (week)
O Days (week-end) O Evenings (week-end) O Nights (wk-end)

V M S N Outside activities with residents (cinema, etc...)

V M S N Organising parties, activities, etc...

V M S N Support to families or friends (during and after resident's stay)

V M S N Errands (for the residents or for the home)

V M S N Internal newsletter

V M S N Kitchen (to serve or to help prepare the meals)

V M S N Laundry (for the residents or for the home)

V M S N Seasonal maintenance (wash walls, etc...)

V M S N General maintenance (paint, repairs, etc...)

V M S N Hairdressing (only with appropriate training)

V M S N Administrative(secretarial, reception, telephone, photocopies, etc.)

V M S N Fundraising (donations, solicitation, activities, etc.)

V M S N Training of Maison d'Hérelle staff
(training and experience required)

V M S N Other, specify: _____

I would like to become a volunteer at Maison d'Hérelle,

Signature: _____ Date: _____