Friends of the Women's & Children's Hospital Inc.
Shops Auxiliary Division

Thank you for your interest in volunteering with The Friends of the WCH Inc. Shops Auxiliary Division

Kindly complete the enclosed application form and send it back to Friends of WCH by:

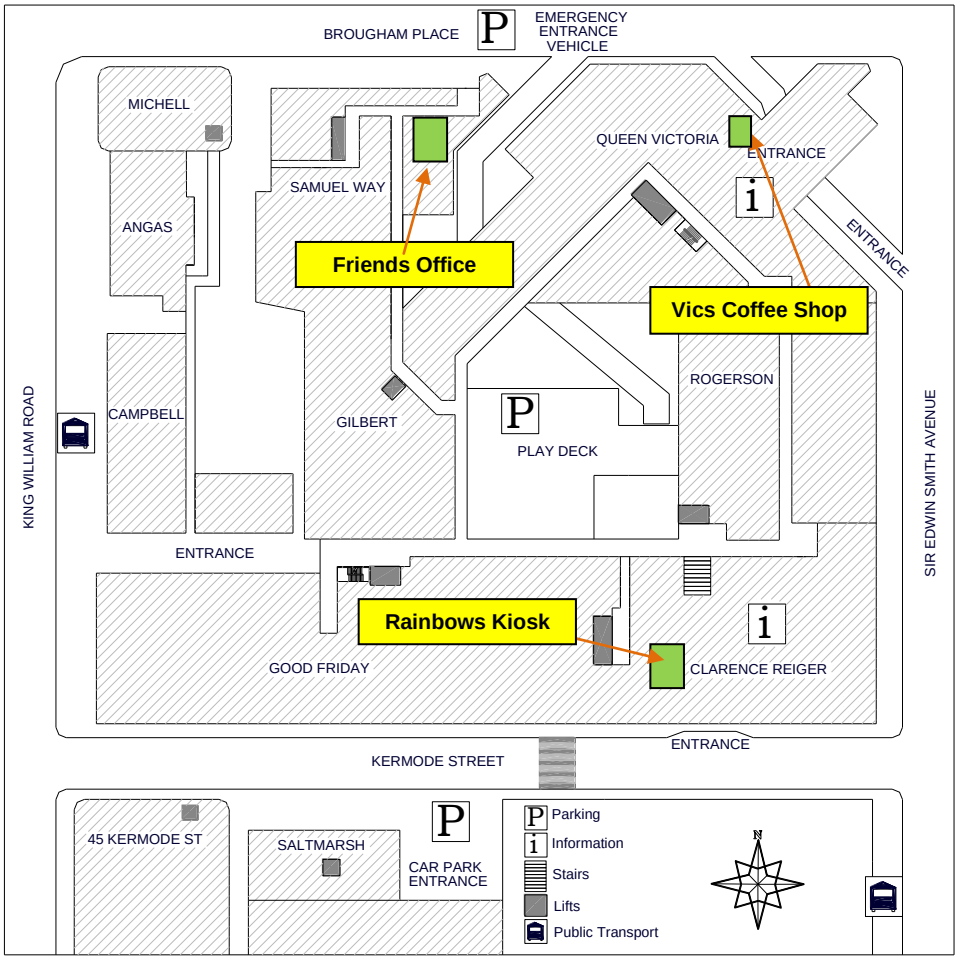
1. Email
   To: Sonia.Davies@sa.gov.au
   or,

2. Post
   The Friends of the WCH Office
   Women's & Children's Hospital
   72 King William Road
   NORTH ADELAIDE SA 5006
   or,

3. Deliver it
   To: Friends Office located on the Ground Floor, Samuel Way Building

If you have any queries please do not hesitate to contact us on 8161 6439 or 8161 8445

We look forward to hearing from you!



APPLICATION FOR THE FRIENDS OF THE WCH INC.

SHOPS AUXILIARY DIVISION

Name ..... Mr/Mrs/Ms
given names *surname* *please circle*

Address .....

.....

Email address .....

☎H ..... ☎W ..... ☎M .....

Date of birth .....

Indigenous status Aboriginal ☐ Torres Strait Islander ☐ Both A & ATSI ☐

Country of birth *only if not Australia* .....

Arrived in country in last 3 months No ☐ Yes ☐ *If yes, which country* .....

Languages ....
spoken *read*

Are you currently employed? No ☐ Yes ☐ Hours per week? .....

Have you or are you currently volunteering with another organisation? *Give details*

.....

Describe your skills and interests

.....

What experience have you had with food handling, customer service? *Give details*

.....

How did you find out about the volunteering within the Shops Auxiliary Division?

.....

Reason for volunteering

- ☐ Recently retired
- ☐ Career move into the area of hospitality
- ☐ Helping others
- ☐ Experience for future employment
- ☐ Have had previous contact with WCH *either as a patient or parent*
- ☐ Gaining social connection with local community
- ☐ Other – please state .....

AVAILABILITY

Please indicate your **PREFERRED DAY(S) AND TIME(S)**

- ☐ Mondays
- ☐ Tuesdays
- ☐ Wednesdays
- ☐ Thursdays
- ☐ Fridays
- ☐ Saturdays
- ☐ Sundays

- ☐ Morning
- ☐ Afternoon

- ☐ Weekly
- ☐ Fortnightly
- ☐ Monthly
- ☐ Other .....

Hours per week:.....

Comments.....

.....

MEDICAL INFORMATION

Please give details of any medical conditions that may impact, effect or limit the type of activities you can participate in during your voluntary work

Please give detail if applicable .....

.....

.....

Do you take medication?

NO ☐ YES ☐

Please give detail if applicable .....

.....

.....

REFERREES

Name of 2 referees - *not members of immediate family*

NAME	TELEPHONE

EMERGENCY CONTACT DETAILS

Please provide names for 2 contact people

FIRST CONTACT NAME .....

Address .....

Telephone home ..... Mobile .....

Relationship .....

SECOND CONTACT NAME .....

Address .....

Telephone home ..... Mobile .....

Relationship .....

In case of illness, name of medical practitioner .....

Telephone .....

DECLARATION

I understand that I automatically become a member The Friends of the Women's & Children's Hospital Inc. when volunteering within the Shops Auxiliary Division.

I agree to abide by the Rules and Regulations of The Friends of the WCH Inc. Constitution and abide by the Rules and Regulations of the Women's & Children's Health Network.

I declare that the information included in this application is true and correct.

Signed ..... Date .....

Thank you for your interest in volunteering with The Friends of the WCH Inc. / Shops Auxiliary Division

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We look forward to hearing from you!