Richmond Hospital/Healthcare Auxiliary
Thrift Shop Volunteer Application
3731 Chatham Street, Richmond, BC
Telephone: 604-271-1551

The Thrift Shop accepts applications from individuals over 16 years of age

Last Name:______________________ **First** Name: ______________________

Address:____

City: ______________________________ Postal Code: ______________________

Telephone: Home: ____________________ Cell: _____________________________

Work: ______________________________ Email: ____________________________

Birth date (optional):_________________
Day / Month

Current Employer: ____

If you are currently a student, what school/university do you attend? ______________________

Year and/or Grade: ____

Other employment and/or Volunteering Experience: ______________________________

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Skills you wish to share: ____

____

Languages spoken fluently: ____

Why are you interested in volunteering with us? ___________________________

____

Please comment on any relevant health conditions or disabilities you may have: ______________

____

In case of emergency contact:

Name:____

Relationship:____

Telephone:____

References: Please list 2 people (not family and preferably not friends) we can contact for a reference.

1) Name:________________________________ Telephone:____________________________

How do you know this person? ____

2) Name:________________________________ Telephone:____________________________

How do you know this person? ____

Availability: Please indicate the blocks of time you are available to volunteer on a regular basis:

Available for Shop Special Events: Yes ☐

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9:30 – 3:30	9:30 – 3:30	9:30 – 3:30	9:30 – 3:30	9:30 – 3:30	9:30 – 3:30	9:30 – 3:30
9:30 – 12:30	9:30 – 12:30	9:30 – 12:30	9:30 – 12:30	9:30 – 12:30	9:30 – 12:30	9:30 – 12:30
12:30 – 3:30	12:30 – 3:30	12:30 – 3:30	12:30 – 3:30	12:30 – 3:30	12:30 – 3:30	12:30 – 3:30

Length of commitment (please circle):

4 months   6 months   1 year   Other: ____________________

I hereby certify that the information contained in this application is true to the best of my knowledge and I give permission to the Richmond Hospital/Healthcare Auxiliary to contact my references. I understand a criminal record check will be required. I also understand by signing this application form, Vancouver Coastal Health will keep a record of my personal information on file. The information you provide on this form is considered confidential by Vancouver Coastal Health and will only be used to manage the application, selection and coordination of volunteers.

Signature: ____________________________ Date: ________________

Office Use Only:

Application: ______________ CRC: ______________ Start Date: ____________

Training: ______________ IMPACT: ______________ End Date: ____________

THANK YOU FOR YOUR INTEREST IN VOLUNTEERING WITH THE

RICHMOND HOSPITAL/HEALTHCARE AUXILIARY THRIFT SHOP