Alexandra Hospital
A member of the NUHS

Application Form
Join us as an Alex Advocate!

Thank you for your interest in volunteering with Alexandra Hospital. Advocates play a crucial role in our journey to create a quality patient experience, and we thank you for investing your time and resources as our friend and advocate.

To help us process your application, please complete this form and email/return it to:

Alex Advocates
c/o Strategic Communications
AH_Advocates@nuhs.edu.sg | +65 6370 6916
Alexandra Hospital, Blk 20B, Level 2, 378 Alexandra Road, Singapore 159964

All information provided will be treated in strict confidence.

Please affix a recent photo of yourself here.

1 PERSONAL PARTICULARS (*Please select accordingly)

Full Name: (Please underline surname)	**Contact Number:** _____ (Mobile/Home) **Email:** _____
Nationality: _____ **Race:** _____	**Gender*:** Male / Female **Age:** _____
Occupation: ☐ Student ☐ Working Adult ☐ Homemaker ☐ Retiree ☐ Others (Please specify) _____	**Languages (spoken)** ☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Others: _____ **Dialects (spoken)** ☐ Hokkien ☐ Teochew ☐ Cantonese ☐ Others: _____
EMERGENCY CONTACT **Name:** _____ **Relationship:** _____ **Contact Number:** _____	

2 EXPERIENCE IN VOLUNTEER WORK

Name of Organisation	Period of Service	Description

3 SKILLS/AREAS OF INTEREST

Please list any skills which you can share during your volunteer stint with us:

Please tick the activity(s) that interest you.

I am interested!	Activity	Description
Around the Hospital		
	Wayfinding	Help our visitors and patients navigate within the hospital.
	Gardening / Horticulture Therapy	Create a healing environment for our patients by tending to our gardens and assisting in horticulture therapy activities.
Patient-Related		
	Befriender	Socialise with patients; befriend and engage them in diversional activities such as bringing them to enjoy walks in the gardens.
	Sitter / Minder	Interact with patients identified to be at high risk of falls and alert the nurse when patients attempt to engage in fall-risk behavior such as getting out of bed unaided. Advocates will be trained to engage patients in diversional activities.
	Dementia & Rehab Care	To engage patients in group or individual rehabilitation activities and exercises, e.g. arts and crafts.
Outside the Hospital		
	Home Care Visits / Hair Cuts	Assist in promoting the health and well-being of patients by carrying out tasks to promote good personal health and hygiene, and to support them.
	Event Support	Ad-hoc support for events, e.g. community health screenings.

4 AVAILABILITY

Please indicate your availability.

Ward activities are typically conducted from Monday to Friday between 2.00pm and 5.00pm. Other activities have specific schedules that you will be informed of.

Days (e.g. Monday): _____

Times (e.g. 8am to 10am): _____

5 IMMUNISATION AND HEALTH DECLARATION

Please indicate accordingly and submit relevant documentary proof as stated. Documentary proof includes vaccination records extracted from health booklets, or blood test results.

Do you suffer from any physical impairment or disease, including psychiatric or mental illness, deafness, handicap, hypertension, diabetes or heart disease? If yes, please specify: _____	☐ Yes ☐ No

VACCINATION	REQUIREMENTS	DOCUMENTARY PROOF REQUIRED	DATE OF VACCINATION(S)
Measles, Mumps and Rubella (MMR)	2 doses; minimum interval of at least 4 weeks *(*You may start to volunteer after receiving the first dose)*	• Vaccination record; or • Serological evidence (i.e. blood test result) of immunity against all 3 diseases; or • Laboratory confirmation of all three diseases.	Date of 1st dose: _____ Date of 2nd dose: _____ Date of blood test result: _____
Varicella (Chickenpox)	2 doses; at 0 and 4 – 8 weeks *(*You may start to volunteer after receiving the first dose)*	• Vaccination record; or • Serological evidence (i.e. blood test result) of immunity; or • Laboratory confirmation of disease	Date of 1st dose: _____ Date of 2nd dose: _____ Date of blood test result: _____
Tetanus, Diphtheria and Pertussis (Tdap)	1 dose of Tdap (if the interval since the last dose of tetanus or diphtheria-containing vaccine was more than 10 years ago)	• Vaccination record with Tdap or Td in the last 10 years	Date of vaccination: _____

6 AGREEMENT

I confirm that all the information provided in this form is true, accurate and complete.

I hereby grant permission to Alexandra Hospital to use my personal data and the information provided in this form:-

a) to review my application to be an Alex Advocate, and assess my suitability for any volunteer programme(s);
b) to contact me on all matters relating to my participation as an Alex Advocate, including keeping me updated of any current and future volunteer programme(s), through the use of electronic and non-electronic forms of communication;
c) where necessary, to disclose my personal data to relevant external organisations or individuals to fulfill the registrations/approvals required, as well as for all matters relating to my participation as a volunteer with Alexandra Hospital; and
d) to use any photographs, videos or audio recordings taken of me during Alexandra Hospital's volunteer programme(s) or whilst at Alexandra Hospital premises for publicity purposes.

I agree to adhere to all safety policies and requirements of Alexandra Hospital and as advised by its staff. I understand that Alexandra Hospital is not responsible for any illness or injury that I may contract or suffer during my volunteer services or whilst at Alexandra Hospital premises.

I will consider as confidential all information that I may gain or have access to in my volunteer position, directly or indirectly, concerning Alexandra Hospital and/or its patients, doctors, nurses, staff and/or any other individuals. I understand that my volunteer position will be terminated as a result of any breach of confidentiality.

I also understand that Alexandra Hospital reserves its rights to terminate my volunteer services and restrict my access to Alexandra Hospital premises at any time to ensure that the well-being and safety of Alexandra Hospital's staff, patients and visitors are maintained at all times.

I agree to indemnify Alexandra Hospital and its staff against all claims, liability and expenses they may suffer in connection with my breach of any of the above conditions and/or my participation in any volunteer programme(s).

FOR ALL ADVOCATES

(For Advocates below 21 years old, please complete the additional section on Parental Consent.)

Signature: _____ **Date:** _____

FOR ADVOCATES BELOW 21 YEARS OLD – PARENTAL CONSENT

I, _____ (Name of *Parent/Guardian), allow my *child/ward _____ (Name) to volunteer with Alexandra Hospital. I understand that by signing on the below, I am agreeable to all the clauses stated as above.

Signature of *Parent/Guardian: _____ **Date:** _____
Contact Number: (Home) _____ (Mobile) _____

Thank you for choosing to volunteer with us.