

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 8879 9070
Alexandra Hospital, Blk 20B, Level 2, 378 Alexandra Road, Singapore 159964

All information provided will be treated in strict confidence.

1 PERSONAL PARTICULARS (*Please select accordingly)

Full Name (Please underline surname)		Contact Number	
		E-mail	
Nationality		Gender* Male / Female	
Race		Date of Birth (dd/mmm/yyyy)	
Occupation <input type="checkbox"/> Student <input type="checkbox"/> Working Adult <input type="checkbox"/> Homemaker <input type="checkbox"/> Retiree <input type="checkbox"/> Others (Please specify) _____	Languages (Spoken) <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay <input type="checkbox"/> Tamil <input type="checkbox"/> Others (Please specify) _____	Dialects (Spoken) <input type="checkbox"/> Hokkien <input type="checkbox"/> Teochew <input type="checkbox"/> Cantonese <input type="checkbox"/> Others (Please specify) _____	
Emergency Contact Name _____ Relationship _____ Contact Number _____			

2 EXPERIENCE IN VOLUNTEER WORK

Name of Organisation	
Period of Service	Frequency
Description	
Name of Organisation	
Period of Service	Frequency
Description	
Name of Organisation	
Period of Service	Frequency
Description	

3 SKILLS / AREA OF INTEREST

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

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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)	Time (e.g. 8am to 10am)
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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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Vaccinations	Requirements	Documentary Proof Required	Date of Vaccinations
Measles, Mumps and Rubella (MMR)	2 doses; minimum interval of at least 4 weeks (You may start to volunteer after receiving the first dose)	<ul style="list-style-type: none"> • 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 1 st dose: _____ Date of 2 nd 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)	<ul style="list-style-type: none"> • Vaccination record; or • Serological evidence (i.e. blood test result) of immunity; or • Laboratory confirmation of disease 	Date of 1 st dose: _____ Date of 2 nd dose: _____ Date of blood test result: _____

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

I accept the above and declare that all the information provided is true and accurate.

Signature: _____ Date: _____

FOR ADVOCATES BELOW 21 YEARS OLD – PARENTAL CONSENT

I, Parent/Guardian of the abovementioned Advocate, accept the above and declare that the information provided is true and accurate.

Name of Parent / Guardian*: _____

Contact Number: _____ (Home/Mobile)

Signature: _____ Date: _____

Thank you for choosing to volunteer with us.