Government of **Western Australia**
East Metropolitan Health Service

EXPRESSION OF INTEREST
WOOL-LAR ABORIGINAL VOLUNTEER PROGRAM

Thank you for your interest in being a WOOL-LAR Volunteer with East Metro Health Service. We are delighted that you want to be a part of the work we do with Aboriginal patients and their families and visitors.

Please fill in the form below to help us find the right role for you. Please send the completed form to: EMHS.AboriginalVolunteers@health.wa.gov.au

Title: _______

First Name: _________________________________

Surname: __________________________________

Address:

____

____

Telephone No: ______________________________ **Mobile:** ________________________

Email:

____

How often would you like to come in and volunteer?

☐ Daily ☐ Weekly ☐ Monthly ☐ Every Second Month

How long would you like to volunteer for?

☐ 3 months ☐ 6 months ☐ 12 months ☐ More than a year

What day/s and time/s would suit you to come in and volunteer?

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
AM (Time)							
PM (Time)							

Do you speak another language other than English?

☐ No ☐ Yes: Which language? ____

COVID-19 Vaccination Status:

☐ Fully Vaccinated

☐ Partially Vaccinated

☐ Exempt from Vaccination

☐ Not Yet Vaccinated

If you have the evidence of your vaccination or exemption, please attach to the form.

Please tell us about your interests, skills, hobbies and past experiences that may be of benefit to the volunteer role at EMHS.

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Why would you like to volunteer with EMHS?

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How did you find out about volunteering at EMHS?

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How did you hear about the WOOL-LAR Aboriginal Volunteer Program?

☐ Newspaper (Please State……………………………)
☐ Internet
☐ Word of Mouth
☐ EMHS Staff / Friend / Volunteer
☐ Other (Please State……………………………)

Please provide contact information for a professional and personal referee:

1. Name: ______________________________

   Contact No: ______________________________

   Email address: ______________________________

2. Name: ______________________________

   Contact No: ______________________________

   Email address: ______________________________

Agreement & Signature:

I understand that prior to working as a volunteer with the WOOL-LAR Aboriginal Volunteer Program at EMHS I will be required to complete the relevant checks and forms.

By submitting this form, I agree to these checks and will provide true and correct information about my identity to complete them.

Name: ____

Signature: ____

Date: _____________________

For any further information please contact

Leah Wood on 0404 454 754 or

EMHS.AboriginalVolunteers@health.wa.gov.au