

HOSPICE CARE

VOLUNTEER APPLICATION

Thank you for your interest in becoming a hospice volunteer. Please complete both sides of this application and return it to the address listed.

Name (Last, First, MI)	Are you over 16 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthday (Mo/Day)
Address	Home Phone #	
City, State, Zip Code	Pager/Cell Phone #	
Employer	Work Phone #	
Occupation/School Attending	Working Hours:	
Email address		
Total number of hours per week you could be available for hospice volunteering: <input type="checkbox"/> Daytime_____ <input type="checkbox"/> Evenings_____ <input type="checkbox"/> Weekends_____ <input type="checkbox"/> Other_____		
Level of Education: <input type="checkbox"/> High School <input type="checkbox"/> 2 Yr College <input type="checkbox"/> 4 Yr College <input type="checkbox"/> Post graduate		

Foreign languages spoken: _____

Religious Affiliation:

(Optional—this assists us in proper placement of our volunteers. We serve patients regardless of religious affiliation).

Catholic Protestant Jewish None Other_____

Personal Information:

How did you hear about us? _____

Why do you wish to be involved in hospice?

What organizations or clubs do you belong to?

Have you had experience with the terminally ill? Yes No If yes please explain

Has someone close to you died within the past year? Yes No If yes please explain

What do you like about yourself?

- Yes No Do you have available transportation for your volunteer work?
- Yes No Do you have a valid California driver's license
- Yes No Do you have automobile liability insurance?
(Auto insurance is required if you use your car for hospice work)
- Yes No Have you been convicted of a felony within the last 7 years?
(Conviction will not necessarily disqualify you from volunteering.)

List experiences you believe would be helpful to you in hospice volunteering, i.e., schooling, work, volunteer experience, office skills, arts and crafts, etc.

Date	Type of Experience

Areas of Interest: (please check areas of interest)

Direct:

- | | | |
|---|---|--|
| <input type="checkbox"/> Patient and/or family visits | <input type="checkbox"/> Meal preparation | <input type="checkbox"/> Shopping/run errands |
| <input type="checkbox"/> Relieve primary caregiver | <input type="checkbox"/> Read to patient | <input type="checkbox"/> Homemaking chores |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Write letters | <input type="checkbox"/> Child care |
| | | <input type="checkbox"/> Bereavement follow-up |

Indirect:

- | | | |
|--|--|--|
| <input type="checkbox"/> Speaker's bureau | <input type="checkbox"/> Sewing/crafts | <input type="checkbox"/> Computer work |
| <input type="checkbox"/> Office assistance | <input type="checkbox"/> Videotaping | <input type="checkbox"/> Music or entertaining |
| <input type="checkbox"/> Mass mailings | <input type="checkbox"/> Photography | <input type="checkbox"/> Host/hostess for hospice events |

Personal References: (with phone numbers)

1. _____
2. _____

In Case of Emergency:

Name: _____ Relationship _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Ext. _____

Physician: _____ Office Phone : (_____) _____

APPLICANT SIGNATURE: _____ **DATE:** _____