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VOLUNTEER APPLICATION

Name of Applicant _____ Birthdate _____
Please print

Address _____
Street City/State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ Can receive calls at work: Yes No Emergency Only

Social Security No. _____

Person to be notified in case of an emergency
Name _____ Phone: Home _____ Business _____
Address _____
Name of Business/Street/Apt. or Suite # City OK Zip Code

Education/Special Training

Work Experience

Personal References Please list two people whom we may contact (excluding family members).

Name _____

Address _____
Name of Business/Street/Apt. or Suite # City OK Zip Code

Home Phone _____ Business Phone _____ Cell _____

Name _____

Address _____
Name of Business/Street/Apt. or Suite # City OK Zip Code

Home Phone _____ Business Phone _____ Cell _____

Identified areas of interest:

Direct Patient/Family Care

- ____ Companionship/Visits
- ____ Internship - Pastoral
- ____ Internship – Nursing
- ____ Errands/Shopping
- ____ Writing or Videotaping
Patient’s Life Story
- ____ Other _____

Indirect Services

- ____ Community/Public
- ____ Administrative/Office
- ____ Crafts/Sewing/Knitting
- ____ Pet Therapy
- ____ Fundraising

Indirect Services Cont’d.

- ____ Hospitality
- ____ Photography
- ____ Calligraphy
- ____ Speakers Bureau
- ____ Computer (graphics,
website, data entry)

Are you fluent in a language other than English?

- Language _____ Speak Read Write
- Language _____ Speak Read Write

Other special services: (manicurist, hairdresser, printer, etc.)

Do you have access to transportation? Yes No

Availability for Volunteer Services:

- Weekdays Weekends Evenings Mornings Afternoons

How did you hear about the Seasons Hospice Volunteer Program?

Why do you want to be a hospice volunteer?

What qualities (skills, talents, knowledge and experiences) do you feel you can incorporate into your hospice volunteer work?

Has someone close to you died with the past year? Yes No

If Yes, please explain: _____

FOR DIRECT PATIENT/FAMILY CARE VOLUNTEERS ONLY

DEATH AND DYING

Do you fear death? _____

Have you ever been with someone at the time of their death? _____

Have you ever been a caregiver to anyone? Yes No

If Yes, please explain: _____

When thinking of your own death, what words best describe death to you?

- I do not think about my own death. Sorrowful Natural Frightening
 Painful Lonely Joyful Peaceful Dark

Other thoughts and feelings about death _____

COMMENTS:

Thank you for your interest in the Volunteer Program at Seasons Hospice. Seasons Hospice is an equal opportunity employer dedicated to a policy of non-discrimination on any basis, including race, color, creed, religion, age, sex, national origin, ancestry, sexual orientation, marital status, military status or the presence of a physical, mental, medical condition or disability.

I understand that I will be offered and be required to complete Hospice Volunteer Training. I agree to fulfill all requirements related to my role as a Volunteer with Seasons Hospice.

Signature of Applicant

Date