HOSPICE VOLUNTEER APPLICATION

Name of Applicant_____

Address_____
Street City/State Zip Code

Home Phone_____Cell Phone_____Work Phone_____

E-mail_____Can receive calls at work: Yes No Emergency Only

Education/Special Training

_____

_____

Work Experience

_____

_____

_____

_____

Have you ever been convicted of a felony, or within the last 5 years a misdemeanor which resulted in imprisonment?
_____Yes _____No

If yes, explain**:** _____

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

Name_____ Relationship_____

Address_____
Street City/State Zip Code

Home Phone_____Business Phone_____Cell_____

Name_____ Relationship_____

Address_____
Street City/State Zip Code

Home Phone_____Business Phone_____Cell_____

Areas of interest

Direct Patient/Family Care
_____Companionship/Visits
_____Internship – Pastoral
_____Internship – Nursing
_____Errands/Shopping
_____Writing or Videotaping
_____Pet Therapy
_____ We Honor Veterans/Veterans History Project/Honor Flight
_____ Caregiver Respite
_____ Activities at facilities
_____ Music Therapy
_____ Housekeeping/Home Repairs
_____ Bereavement Support

Indirect Services
_____ Volunteer In-Services/Meetings
_____ Bereavement Support, Office
_____ Administrative/Office, general
_____ Giving Corner/Food Bank
_____ Receptionist Support
_____ Filing
_____ Mailings
_____ Data Entry
_____ Singing/Music at facilities
_____ Other _____
_____
_____
_____

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

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_____

_____

Additional Comments**:**

_____

_____

_____

Thank you for your interest in the Volunteer Program at Seasons or Crown Hospice. Seasons and Crown are equal opportunity employers 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 or Crown Hospice. I understand as a volunteer I will be subject to a criminal background check, a drug and/or alcohol screen, using urine or blood tests. In the event of a disability that will affect the ability to take the test, the hospice will be informed to determine if reasonable accommodations can be made. Seasons and Crown Hospice reserves the right to require medical documentation concerning the need for the accommodations.

_____

Signature of Applicant Date