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hospice support care

Volunteer Application

Name: _____ Date: _____

Address: _____ Phone: Home: _____

City, State, Zip: _____ Phone: Cell: _____

Date of Birth: _____ E-mail address: _____

Are you presently employed/studying: _____ Full or Part-time: _____

Occupation/Course of Study: _____

What languages do you speak? _____

What type of special training do you have?

What are your other interests? What do you like to do?

How did you hear about Hospice Support Care?

Have you recently experienced a loss through death? ____ Has this been in the past year? ____

If so, please describe briefly:

Have you spent time with someone with a life-altering or terminal illness and /or dying? _____

If so, please describe briefly:

What motivates you to work with Hospice Support Care?

Please specify what hours you are available:

Weekdays: __Morning __Afternoon __Evening

Weekends: __Morning __Afternoon __Evening

Do you have any medical or physical conditions or limitations? _____

Describe: _____

Are there situations you would not be comfortable with (i.e. cigarette smoke, pets)? _____

Is there anything else you would like us to know? _____

Areas of Interest:

Patient/Family Care:

___In home

___Nursing home

___Transportation

Bereavement:

___Adults

___Children/Teens

___Caller

Non-Patient Services:

___Administrative

___Special Events

___Grant Writing

___Thrift Shop

___Volunteer Voices

References:

Two references (non-family members) are required. Please provide a complete address as references are verified by mail.

Name _____ Relationship _____

Address _____

Street

City

State

Zip Code

Phone _____ Email _____

Name _____ Relationship _____

Address _____

Street

City

State

Zip Code

Phone _____ Email _____

Thank you for your interest in volunteering with Hospice Support Care.