



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 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	DOB (Month/Day)
Address:	Home Phone:	
City, St, Zip:	Cell/Pager:	
Employer:	Work Phone:	
Occupation:	Working Hours:	
E-Mail 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 Year College <input type="checkbox"/> 4 Year College <input type="checkbox"/> Post Graduate		
Foreign languages spoken:		

RELIGIOUS AFFILIATION (optional -- this assists us in proper placement of our volunteers. We server 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 any experience with the terminally ill? Yes No

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



	Yes	No
Do you have available transportation for your volunteer work?		
Do you have a valid California driver's license?		
Do you have automobile liability insurance? (Auto insurance is required if you use your car for hospice work)		
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., education, work, volunteer experience, office skills.

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"/> Write letters | | |
| <input type="checkbox"/> Bereavement follow-up | | |

Indirect:

- | | |
|--|--|
| <input type="checkbox"/> Speakers bureau | <input type="checkbox"/> Music or entertaining |
| <input type="checkbox"/> Office assistance | <input type="checkbox"/> Host/hostess for hospice events |
| <input type="checkbox"/> Mass mailings | |

PERSONAL REFERENCES:

Name	Relationship	Phone

IN CASE OF EMERGENCY:

Name:	Relationship:
Home Phone:	Work Phone:
Physician:	Phy. Phone:

Applicant Signature:	Date:
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