



Volunteer Application

Name _____

Street Address _____

Home Phone _____ Cell/Work Phone _____

E-mail address _____

What is the best way to contact you? _____

Date of Birth ___/___/___ Are you 18 years of age? YES NO

Emergency Contact Name _____

Emergency Contact Phone Number _____

Emergency Contact Relationship _____

Areas of interest:

- | | |
|--|--|
| <input type="checkbox"/> Patient Companionship | <input type="checkbox"/> Office/ Clerical |
| <input type="checkbox"/> Patient Socialization | <input type="checkbox"/> Reading/ Letter Writing |
| <input type="checkbox"/> Caregiver Companionship | <input type="checkbox"/> Caregiver Respite |
| <input type="checkbox"/> Caregiver Socialization | <input type="checkbox"/> Complimentary Therapy |
| <input type="checkbox"/> Bereavement Volunteer | <input type="checkbox"/> 11 th Hour Support |
- (Sit with a patient who is close to death)

Special talents or training:

(Continued on back)

Previous Volunteer Experience:

Why do you want to volunteer in a hospice setting?

Have you experienced a recent death?

Availability: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

Morning Afternoon Evening As Needed

Other: _____

Please list 2 references:

1. Name _____
Relationship _____
Phone Number _____

2. Name _____
Relationship _____
Phone Number _____

How did you hear about this volunteer opportunity?
