HOPE
HEALTHCARE AND HOSPICE

VOLUNTEER APPLICATION FORM

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ DOB: _____

Cell Phone: _____ Email Address: _____

Occupation: _____ Marital Status: _____

****

Person to Notify in Case of Emergency:

Name: _____ Phone: _____

Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Carrier: _____

****

Are you 16 years of age or older? ☐ Yes ☐ No

Have you ever been convicted of a serious driving offense or other crime? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any impairments—physical, mental, or medical—which would interfere with your ability to perform volunteer duties for which you have applied?

☐ Yes ☐ No If yes, describe: _____

Do you have a current driver's license? ☐ Yes ☐ No DL #: _____

Do you have access to an automobile? ☐ Yes ☐ No

Do you have liability insurance on you vehicle? ☐ Yes ☐ No

PLEASE LEAVE A COPY OF DRIVER'S LICENSE AND CAR INSURANCE CARD WITH VOLUNTEER COORDINATOR.

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Death and Dying

Have you ever provided care to anyone who was dying? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Military History: ☐ Yes ☐ No If yes, please indicate branch: _____

Identified Areas of Interest

_____ Sit with patient
_____ Call patients/caregivers
_____ Light house work for patient's
_____ Yard work
_____ Florist
_____ Write cards or letters
_____ Making gifts/deliver
_____ Visit patient
_____ Musician
_____ Tuck in Program
_____ Make a meal/baked goods/delivery to patients
_____ other special interest

Availability: When are you available? (Please check all that apply):

Mondays:	Mornings_____	Afternoons_____	Evenings _____
Tuesdays:	Mornings_____	Afternoons_____	Evenings _____
Wednesdays:	Mornings_____	Afternoons_____	Evenings _____
Thursdays:	Mornings_____	Afternoons_____	Evenings _____
Fridays:	Mornings_____	Afternoons_____	Evenings _____
Saturdays:	Mornings_____	Afternoons_____	Evenings _____
Sundays:	Mornings_____	Afternoons_____	Evenings _____

Background/Preferences

Why do you want to be a hospice volunteer?

_____

_____

_____

_____

_____

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Please list any preferences/sensitivities you may have (Ex: Allergic to dogs, non-smoker/smoker, pet friendly):

References

Please provide us with two references below that you are not related to you whom you have known at least one year. HOPE Healthcare and Hospice will be contacting the following references.

Reference #1

Name	
Street Address	
City, State, Zip Code	
Phone Number	

Reference #2

Name	
Street Address	
City, State, Zip Code	
Phone Number	

I authorize HOPE Healthcare and Hospice to contact the above-listed persons for the purpose of obtaining references. I understand all information will be kept confidential and release from liability any person giving or receiving information. I also hereby release from liability the potential employer and its representatives for seeking, gathering, and using such information to make employment decisions and all other persons or organizations for providing such information.

I understand and agree that any material misrepresentation or deliberate omission of a fact in my application may be justification for refusal of, or if activated as HOPE Healthcare and Hospice volunteer, termination from volunteerism.

Signature: _____ Date: _____