

Sacred Journey Hospice
Application for Adult Volunteer Service

Days Can Work: (Mon.) ___ (Tues.) ___ (Wed.) ___ Thurs.) ___ (Fri.) ___ (Sat.) ___ (Sun.) ___

Hours Can Work: (9 - 12) ___ (12 - 3) ___ (3 - 6) ___ (6 - 9) ___ Prior Military Y ___ N ___

Name: (Mr.) (Mrs.) (Miss) _____ Preferred Name: _____

Email Address: _____

Home Address: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Business Address: _____ Zip Code: _____

Type of Work: _____

Birthdate: _____ Married: ___ Widowed: ___ Single: ___ Separated: ___

Spouse's Name: _____ Business: _____ Phone: _____

Previous Volunteer Experience: _____

Physical Limitations: _____

Which of the following areas would you be interested in or feel you could best contribute to Hospice? Circle the ones that apply.

- | | |
|--------------------------------------|----------------------------|
| Patient Care | Volunteer Training |
| Patient / Family House Work | Office Assistance |
| Patient / Family Yard Work | Medical Director |
| Patient Friendship Needs | Accounting / finance |
| Patient / Family Errands | Business / Patient Records |
| Family Counseling | Clerical / Typing |
| Patient Counseling | Medicare Reimbursement |
| Bereavement Counseling | Family Insurance Claims |
| Group Staff Counseling | Social Work |
| Coordinating Volunteers | Public Relations Media |
| Spiritual Counseling | Legal Assistance |
| Funeral Arrangements | Fund Raising |
| Insurance Forms / Records Assistance | Telephone / Reception |
| Legal Assistance – Family | Equipment Maintenance |
| Financial Planning | Hospice Speaker Bureau |

Are there other areas where you could contribute? (Yes) _____ (No) _____

Explain: _____

Please list skills / disciplines you are licensed or certified for: _____

Do you have transportation? (Yes) _____ (No) _____ Auto Insurance? (Yes) _____ (No) _____

Foreign Language: _____ (Spoken) ____ (Understood) ____ (Read) ____ (Verbal) ____

Do you know Sign Language or Deaf Communication? _____

Religious Preference: _____

Why do you wish to be a Volunteer? _____

List three (3) references – Name, Address and Phone Number:

1) _____

2) _____

3) _____

Please describe your most significant death experience: _____

Have you ever had a life threatening illness? (Yes, in the past) ____

(Yes, currently in treatment) _____

Applicant's Signature: _____ Date: _____

In case of emergency, notify: _____ Phone: _____

(Other than immediate family)

FOR OFFICE USE ONLY

(Appearance) _____ (Poise) _____ (Enthusiasm) _____

Comments: _____

Will accept the responsibility of record keeping: (Yes) _____ (No) _____

Prepared to attend monthly volunteer meetings: (Yes) _____ (No) _____

Volunteer Training: Date attended with supervisor's initials:

Session 1: _____ Session 2: _____

Session 3: _____ Session 4: _____

Session 5: _____ Session 6: _____

Other : _____ Other: _____

Date of Personal Interview: _____ Interviewer: _____

Application Approved: _____