



CROWN
HOSPICE

HOSPICE VOLUNTEER APPLICATION

Name of Applicant _____

Address _____
Street City/State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ Can receive calls at work: Yes No Emergency Only

Education/Special Training

Work Experience

Have you ever been convicted of a felony, or within the last 5 years a misdemeanor which resulted in imprisonment?
_____ Yes _____ No

If yes, explain: _____

Personal References: Please list two people whom we may contact (excluding family members)

Name _____ Relationship _____

Address _____
Street City/State Zip Code

Home Phone _____ Business Phone _____ Cell _____

Name _____ Relationship _____

Address _____
Street City/State Zip Code

Home Phone _____ Business Phone _____ Cell _____

Areas of interest

<u>Direct Patient/Family Care</u> <input type="checkbox"/> Companionship/Visits <input type="checkbox"/> Internship – Pastoral <input type="checkbox"/> Internship – Nursing <input type="checkbox"/> Errands/Shopping <input type="checkbox"/> Writing or Videotaping <input type="checkbox"/> Pet Therapy <input type="checkbox"/> We Honor Veterans/Veterans History Project/Honor Flight <input type="checkbox"/> Caregiver Respite <input type="checkbox"/> Activities at facilities <input type="checkbox"/> Music Therapy <input type="checkbox"/> Housekeeping/Home Repairs <input type="checkbox"/> Bereavement Support
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<u>Indirect Services</u> <input type="checkbox"/> Volunteer In-Services/Meetings <input type="checkbox"/> Bereavement Support, Office <input type="checkbox"/> Administrative/Office, general <input type="checkbox"/> Giving Corner/Food Bank <input type="checkbox"/> Receptionist Support <input type="checkbox"/> Filing <input type="checkbox"/> Mailings <input type="checkbox"/> Data Entry <input type="checkbox"/> Singing/Music at facilities <input type="checkbox"/> Other _____ _____ _____
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Are you fluent in a language other than English?

Language _____ Speak Read Write

Language _____ Speak Read Write

Other Special Services: (manicurist, hairdresser, printer, etc.)

Do you have access to transportation? Yes No

Availability for Volunteer Services:

Weekdays Weekends Evenings Mornings Afternoons

How did you hear about the Seasons Hospice Volunteer Program?

Why do you want to be a hospice volunteer?

What qualities (skills, talents, knowledge, and experiences) do you feel you can incorporate into your hospice volunteer work?

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

If Yes, please explain: _____

FOR DIRECT PATIENT/FAMILY CARE VOLUNTEERS ONLY

Do you fear death? _____

Have you ever been with someone at the time of their death? _____

Have you ever been a caregiver to anyone? Yes No

If Yes, please explain: _____

When thinking of your own death, what words best describe death to you?

- I do not think about my own death. Sorrowful Natural Frightening Painful Lonely
 Joyful Peaceful Dark

Other thoughts and feelings about death _____

Additional Comments:

Thank you for your interest in the Volunteer Program at Seasons or Crown Hospice. Seasons and Crown are equal opportunity employers dedicated to a policy of non-discrimination on any basis; including race, color, creed, religion, age, sex, national origin, ancestry, sexual orientation, marital status, military status or the presence of a physical, mental, medical condition or disability.

I understand that I will be offered and be required to complete Hospice Volunteer Training. I agree to fulfill all requirements related to my role as a Volunteer with Seasons or Crown Hospice. I understand as a volunteer I will be subject to a criminal background check, a drug and/or alcohol screen, using urine or blood tests. In the event of a disability that will affect the ability to take the test, the hospice will be informed to determine if reasonable accommodations can be made. Seasons and Crown Hospice reserves the right to require medical documentation concerning the need for the accommodations.

Signature of Applicant

Date