Volunteer Application

Thank you for taking the time to apply for our volunteer program. Please fill out the following application as accurately as possible. Thank you.

TODAY'S DATE: _______/_______/_______

FULL NAME:____

HOME ADDRESS:____

APT NO:________ **CITY**:______________________________ **STATE**:_______ **ZIP**:_________

MAILING ADDRESS (if different):____

P.O. BOX:_______ **CITY**:______________________________ **STATE**:_______ **ZIP**:_________

EMAIL ADDRESS:____

HOME:(____)______________ **WORK**:(____)_____________ **CELL**:(____)______________

DATE OF BIRTH:______/______/_______ **SOC. SEC. NO**:______-______-________

DRIVER'S LICENSE: **(State)**_______ **(Number)**______________________________________

EMERGENCY CONTACT:

NAME:____

ADDRESS:____

CITY:____ **STATE**:________ **ZIP**:_________

HOME:(____)______________ **WORK**: (____)_____________ **CELL**:(____)______________

RELATIONSHIP TO YOU:____

EDUCATION AND TRAINING:

School Level Completed:_____________________**Degree/Emphasis**:____________________

Special Training or Certificates:____

____

WORK EXPERIENCE:

CURRENT EMPLOYER:____

DATES:______/______/_______- **Present**

DUTIES PERFORMING:____

____

Can you receive calls at work? YES ___ NO___ Emergency only ___

REFERENCES (Excluding family or relatives):

NAME:____

RELATIONSHIP:__________________________________ **CONTACT #**_________________

NAME:____

RELATIONSHIP:___________________________________ **CONTACT #**_________________

AREAS WHERE YOU'D LIKE TO HELP US (Check all that apply):

Directly with Patients:

___ In their home ___ In their nursing facility ___ Sit, Read, or pray with Patients
___ Alternative therapies ____Entertain Patients ___ Make or give things to Patients

Directly with Patients' family members:

___ Before their loved one passes ___ Making phone calls ___ Don't know yet
___ During their loved one's passing ___ Support groups ___ Home visits
___ After their loved one passes

Help / Support SolAmor Staff:

___ Clerical ___ Mailings ___ Community Projects ___ Other: _______________

What are your personal skills/talents/areas of interest?

___ Arts & Crafts ___ Sewing ___ Singing ___Writing ___Reading aloud ___ Massage

___ Musician:_________________ ___ Manicures ___ Hair styling/grooming

___ Pet Therapy ___ Pet feeding/bathing/walking ___ Other:_____________________

QUESTIONS:

Have you ever been convicted of a felony? Yes___ No___ If yes, please explain: ____________

____

How did you hear about the SolAmor Hospice Volunteer Program? _________________________

Have you ever filed an application with us before? Yes___ No___

Why do you want to become a hospice volunteer? _______________________________________

____

If you speak other languages, which one(s)? ____

If you have allergies, what are they? ____

Can you interact with a patient or their family if they smoke? Yes ___ No ___

Have you personally lost a loved one in the past 12 months? Yes ___ No ___

If yes, explain: ____

Do you have access to transportation? Yes ___ No ___

If accepted, when will you be able to commence? ____/____/______

I certify that the answers given are true and complete to the best of my knowledge.

I authorize SolAmor Hospice to investigate all the statements contained in this application for hospice volunteerism as may be necessary in arriving at the decision, I thereby release employers, schools and other persons from all liability in responding to inquiries in connection with my application.

I hereby understand and acknowledge that unless otherwise defined by applicable law, any volunteer relationship with this organization is of an "at will" nature, which means that the volunteer may resign at any time and SolAmor Hospice may discharge the volunteer at any time with or without cause.

I promise to stay in the rules of patient confidentiality and not discuss any hospice patient outside the immediate hospice circle.

I understand that my role as a volunteer is very important to the patient and family and I will not make false promises. If I am unable to see the patient or family members, I will contact SolAmor Hospice ahead of time.

____ ______________

Signature of Applicant Date

INTERNAL USE ONLY:

___ Background screen completed: ____/____/______

INTERVIEW CONDUCTED BY: ________________________________ DATE: ____/____/______