Volunteer Application

Start Date

☐ **Patient Support** ☐ **Administrative** ☐ **Bereavement** ☐ **Inpatient Care**

Personal Information

Name			Date of Birth
Mailing Address			
City/State/Zip			
E-mail Address			
Phone #'s	Day	Evening	Cell
Emergency Contact:			
Emergency Phone #'s	Day	Evening	
Employer			Phone #
Can you receive calls at work?	☐ Yes ☐ No	☐ Emergency Only	
Do you have a valid driver's license?	☐ Yes ☐ No	If yes, provide number.	
Do you have auto insurance liability coverage?	☐ Yes ☐ No	If yes, name the carrier.	
Describe your general health for the past 12 months. Include any restrictions you wish us to be aware of. (No lifting, no smoking, etc.)			
Have you ever been convicted of a felony? *(a yes answer does not automatically exclude you from becoming a VistaCare Volunteer)*			
☐ Yes ☐ No If yes, please explain:			

Education and Licensures

Please list your educational background including any educational programs, courses, etc. you have attended.

School/Courses	Location	Dates	Degrees/Licenses

Work Experience

Employer	Location	Dates	Position

Volunteer Experience

Organization	Location	Dates	Type Volunteer

VistaCare Volunteer Program

How did you hear about the VistaCare Volunteer Program?
Why do you want to be a hospice volunteer?
Have you experienced the death of someone close to you within the last 12 months? ☐ Yes ☐ No
If yes, please give date and explanation of loss:
Are there additional comments you would like to share?

References (two required)

Name:	Day Phone #:
Mailing Address:	City/State/Zip:
Name:	Day Phone #:
Mailing Address:	City/State/Zip:

I authorize a representative of VistaCare to check my references.

Print name:

Signature: **Date:**

If applicant is under the age of 18 a parent/guardian's permission is required to check references and become a volunteer. Parent/Guardian acknowledges his/her child may be working in a hospice setting where patients reside or are admitted to a facility for palliative management of symptoms associated with a terminal diagnosis.

I understand that a TB screening test is required if volunteer assignment involves direct patient contact and give my permission for a TB screening test to be administered to my child.

Parent/Guardian Signature: _____ Date:_____

V O L U N T E E R S

Make a World of Difference