

## Pre-Screening Requirements for Volunteering

Welcome! We're pleased you will be working as part of our team of professionals. Information about you is a vital step in our pre-volunteer process, ensuring that we do our due-diligence in providing the best care to our patients and their families, while at the same time meeting our volunteer regulations for compliance. All testing and/or screening is done at no cost to the volunteer. **Please note that your work as a volunteer is at-will, and that volunteering with Seasons is contingent upon successful completion of all required employment verifications, presentation of required documents and continued volunteer file compliance as documents expire or are renewed as outlined below:**

**1. A valid state driver's license**

We require a driving record check (MVR) annually for Volunteers who drive as part of their responsibilities.

In order to successfully pass a motor vehicle check, the following must be established:

- An individual must have no more than three moving violations or more than one chargeable accident during the past 36 months, AND
- No major convictions (driving under the influence of alcohol or drugs, reckless driving, etc.) within the past seven (7) years, AND
- No license suspensions or revocations caused by moving violations, DUI, etc., within the past seven (7) years.

**\*\*Administrative Volunteers who drive to and from the office only are exempt from the Drivers License, MVR and Auto Liability Insurance requirement.**

- 2. Proof of current auto liability insurance** meeting the state's minimum requirements. Proof of insurance must include the policy expiration date.
- 3. TB Screening** in accordance with our policy guidelines.
- 4. Successful completion of all State and Federal background check** requirements for the state in which you volunteer. *\*\*Note Social Security Number & Date of Birth are required elements in obtaining these reports.*
- 5. Successful completion of a pre-employment drug screen.**
- 6. Physical, if required for your site location.**
- 7. Proof of current CPR Certification**, if required, for volunteers serving Inpatient Unit settings.
- 8. If volunteering in a capacity that requires licensure (e.g. massage, hair dressing, reiki, etc.), an active, valid professional license or state registry from the state in which you will volunteer.** The license/registry certification must be free of any encumbrances for volunteers providing services requiring licensure.

To meet the above requirements, please provide documentation copies to your Volunteer Director/Coordinator as requested and prior to active service.

*I have read and understand the above requirements for Volunteer Service*

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Volunteer Signature

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Date

**Please sign and return to your Volunteer Director/Coordinator**

# SEASONS HOSPICE & PALLIATIVE CARE VOLUNTEER PROFILE



**\*\*Please complete the front and back side of the profile\*\***

## Please tell us about you!

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## How do we best contact you?

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Has anyone close to you died within the last twelve months? (circle one) Yes No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have any history of criminal conviction? (circle one) Yes No

If yes, list offense(s) and date(s): \_\_\_\_\_  
\_\_\_\_\_

May we have permission to do a background check? (circle one) Yes No

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Other Names Used? \_\_\_\_\_

(Volunteers must possess an untarnished criminal background. Volunteers convicted of a disqualifying offense may not participate in the Direct Patient Care Program. Criminal background checks will be obtained in accordance with state requirements and regulations.)

**Skills and Education:**

List experiences or education that would be helpful to you in hospice, ie: schools, skills, crafts or hobbies:

\_\_\_\_\_

\_\_\_\_\_

Do you speak another language? If yes, please list: \_\_\_\_\_

**Driver Information:**

Do you drive (and have a valid license) ? (circle one) Yes No

Driver's License #: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Expiration date: \_\_\_\_\_

(To participate in our program, volunteers must not have more than 3 moving violations in the past 36 months, a DUI, or reckless driving charges on the Annual Motor Vehicle Record Check.)

**Areas of Interest: (check all that apply)**

- |   |   |
|---|---|
| <u>Direct Patient Care</u>                      | <u>Indirect Care</u>                      |
| <input type="checkbox"/> Companionship          | <input type="checkbox"/> Community Events |
| <input type="checkbox"/> Bereavement            | <input type="checkbox"/> Office Projects  |
| <input type="checkbox"/> Caregiver Relief       |   |
| <input type="checkbox"/> Loyal Friends Pet Team |   |

Other? \_\_\_\_\_

How many miles are you willing to travel to see a patient?  
(round trip)

5 mi.  10 mi.  20 mi.  40 miles

**Personal Information:**

How did you hear about Seasons Hospice & Palliative Care?

Why do you wish to be involved in hospice?

**When are you (generally) available?**

M  T  W  Th

F  Sat  Sun

Mornings  Afternoons  Evenings

**Emergency Notification:**

In case of an emergency, contact (Name): \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date signed: \_\_\_\_\_

Seasons Hospice & Palliative Care Volunteer Program is fully committed to Equal Opportunity and Equal Consideration to all Volunteer Applicants.

# SEASONS HOSPICE & PALLIATIVE CARE CONFIDENTIAL REFERENCE REQUEST



To:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

\_\_\_\_\_ (Volunteer Name) has applied to be a volunteer with Seasons Hospice & Palliative Care. Hospice Volunteers provide companionship, emotional, and spiritual support to improve the quality of life for patients who are facing a life-limiting illness. Seasons Hospice must make every attempt to insure that the personality and aptitude of each volunteer is compatible with this goal. Your name was given as a reference. We would appreciate your taking time to complete the information requested below. Please return the form in the enclosed self-addressed, stamped envelope. Your answers are kept strictly confidential.

In what capacity do you know the applicant? \_\_\_\_\_ Supervisor \_\_\_\_\_ Co-Worker \_\_\_\_\_ Friend \_\_\_\_\_ Other

How long have you known the applicant? \_\_\_\_\_ (months/ years)

Please rate this person in the following areas:

5 = Outstanding      4 = Very Good      3 = Good      2 = Needs Improvement      1 = Unsatisfactory

Patience	5	4	3	2	1	Ability to Listen	5	4	3	2	1
Compassion	5	4	3	2	1	Reliability	5	4	3	2	1
Maturity	5	4	3	2	1	Honesty	5	4	3	2	1
Tolerance for differing religions, cultures, or lifestyles							5	4	3	2	1

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

Reference's Signature

Date

I, \_\_\_\_\_

Applicant's Signature

Date

give permission to release any information which would be relevant to the above position for which I have applied. I release from all liability and indemnity any person, corporation, etc., supplying the information above.

# SEASONS HOSPICE & PALLIATIVE CARE CONFIDENTIAL REFERENCE REQUEST



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 Name: \_\_\_\_\_  
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Maturity	5	4	3	2	1	Honesty	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1					
Tolerance for differing religions, cultures, or lifestyles							5	4	3	2	1	5	4	3	2	1	5	4	3	2	1					

**Additional Comments:** \_\_\_\_\_

\_\_\_\_\_  
Reference's Signature
Date

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