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