Arbor Hospice
DIGNITY • COMFORT • PEACE

VOLUNTEER APPLICATION

PERSONAL INFORMATION (Please Print)

Name: ______________________________ ____________________ ________________
(Last) (First) (Middle Initial)

Street Address: ____

City: ______________________________ State: ____________ Zip Code: ______________

Home Phone: ___________________________ Cell Phone: ___________________________

Work Phone: _____________________________Email Address: ________________________

Are you a student? Yes ☐ No ☐ If yes, what school do you attend? __________________

Have you experienced a death in the family within the past year? Yes ☐ No ☐

EMERGENCY CONTACT INFORMATION

Name: ____________________________________ Relationship: _____________________

Home Phone: _______________ Cell Phone: ______________ Work Phone: ______________

VOLUNTEER HISTORY

ORGANIZATION	FROM (MO/YR)	TO (MO/YR)	POSITION/DESCRIPTION OF ROLE

REFERENCES

Please provide the name, complete address and phone number of two personal or professional references who are not related to you:

Name: ________________________________ Relationship & Phone _______________________
Address: ____

Name: ________________________________ Relationship & Phone _______________________
Address: ____

AREAS OF SERVICE

Please identify the areas of service that interest you (check all that apply):

PATIENT/FAMILY SUPPORT	LIFE ENRICHMENT PROGRAM	ORGANIZATION/STAFF SUPPORT
☐ In Patient's Home	☐ Light Hand Massage	☐ Office Support
☐ In Assisted Living Facility	☐ Massage Therapy	☐ Grief Support
☐ In Nursing Home	☐ Music Sessions	☐ Special Events/Fundraising
☐ At Arbor Hospice Residence	☐ Pet Visitation	☐ Special Projects

SKILLS AND ABILITIES

Please identify all skills and abilities that apply. Also note any special skills and knowledge that might be pertinent for the volunteer position desired.

☐ Computer	☐ Music	☐ Telephone
☐ Language _____________	☐ Public Speaking	☐ Crafting/Sewing

☐ Other pertinent skills, talents, interests, i.e., photography, etc. ____

____

AVAILABILITY

WEEKDAYS	WEEKENDS	OTHER
☐ Mornings	☐ Mornings	☐ ________________________________
☐ Afternoons	☐ Afternoons	________________________________
☐ Evenings	☐ Evenings	________________________________ ________________________________

QUESTIONNAIRE

1. How did you learn about Arbor Hospice?

____

____

2. Why do you want to become a volunteer with our organization?

____

____

3. What values can you bring to our organization?

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____

4. If you were told you only had six months to live, what would you do?

____

____

5. What are your experiences with death/grief, or what is your personal philosophy on death/grief?

____

____

6. In which geographic areas (zip codes) are you willing to volunteer?

____

7. Are you willing to commit to 15 hours of volunteer training and agree to volunteer for a period of at least six months after the completion of training? Yes ☐ No ☐

SIGNATURES AND AUTHORIZATION

I agree to serve as a volunteer with Arbor Hospice. As a volunteer, I understand my assignments may be with patient or non-patient services and that the decision will be made between the Volunteer Coordinator and me. In whatever capacity I serve, the expectation of my role will always be to provide needed services in a professional, caring manner and in accordance with the Patients Rights and Responsibilities and all agency policies and procedures.

I understand that my responsibilities will include:

- Volunteering for a time period of at least six months after the completion of training.
- Maintaining patient/family confidentiality and respecting the Patients Rights and Responsibilities.
- Attending mandatory in-service programs to keep informed of the agency's policies and ongoing initiatives.
- Reliability in carrying out my assignments in a timely and conscientious manner.
- Accurate and timely record keeping/documentation to be provided as directed by the Volunteer Coordinator.
- Completion of all required health assessments to include: initial two-step TB test with annual thereafter or a chest x-ray on file and annual TB symptom list, and an in-service to meet Universal Precautions/OSHA compliance requirements.

In accepting the role of volunteer for the agency, I give authorization for Arbor Hospice to verify the information provided. I certify that all the information submitted by me on this application is true and complete, and I understand that if any false information, omissions, or misrepresentations are discovered, my application may be rejected and my assignment may be terminated at any time.

In consideration of my decision to volunteer, I agree to conform to the Agency's rules and regulations, and I agree that my assignments can be terminated, with or without cause, and with or without notice, at any time, at either my or the Agency's option. I also understand and agree that the terms and conditions of my assignment may be changed, with or without cause, or with or without notice, at any time by the agency.

Please Print Name: ____

Signature: ____ Date: ________________

Witness: ____ Date: ________________