

Please type or print clearly

Date:

NAME AND ADDRESS		
Last name	First	Middle Initial
Current Address		
City	State	Zip
PHONE NUMBERS		E-MAIL ADDRESS
Home	Work	Cell
SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEALTH PROFESSIONAL
		<input type="checkbox"/> N/A <input type="checkbox"/> State Registration #:
EMERGENCY CONTACT INFORMATION		
Name		Phone #
REFERRAL SOURCE		
<input type="checkbox"/> Newspaper	<input type="checkbox"/> Church announcement	<input type="checkbox"/> Community poster
<input type="checkbox"/> Friend	<input type="checkbox"/> Hospice staff/volunteer	<input type="checkbox"/> Other
EXPERIENCE / SKILLS		
<input type="checkbox"/> Volunteering	<input type="checkbox"/> Patient care	<input type="checkbox"/> Office-Clerical
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Pet therapy	<input type="checkbox"/> Spiritual Support
<input type="checkbox"/> Sewing	<input type="checkbox"/> Other:	
REFERENCES - LIST 2 PEOPLE OUTSIDE OF YOUR FAMILY		
Name		Phone #
Name		Phone #
GENERAL INFORMATION		
Why do you wish to volunteer at our hospice?		
What does Hospice mean to you?		
Have you had any personal experiences with death? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, we ask that you wait one year after the death before taking the training		
Have you cared for someone who was dying?		
Is there anyone in your family who is terminally ill?		
How does your family feel about you volunteering for Hospice?		
What qualities do you think are your strong points?		
Signature:		