



**VOLUNTEER APPLICATION**

Date: \_\_\_\_\_

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

Address: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Are you legally eligible for employment in the U.S.?  Yes  No

1. Why are you interested in volunteering?

\_\_\_\_\_  
\_\_\_\_\_

2. What other volunteer experiences have you had?

\_\_\_\_\_  
\_\_\_\_\_

3. Have you experienced a significant loss in the past 12 months?  Yes  No

Death  Divorce  Move  Career / School Change

4. How do you cope with change / loss?

\_\_\_\_\_  
\_\_\_\_\_

**AVAILABILITY**

Days  Evenings  Nights  Weekends

**AREAS OF INTEREST**

Patient / Caregiver Interaction  Bereavement  Crafting  Administrative Support

5. Are you currently employed?  Yes  No If yes, place of employment: \_\_\_\_\_

6. What are your hobbies or interests? \_\_\_\_\_

\_\_\_\_\_

7. List languages that you are fluent in: \_\_\_\_\_

Please provide two complete references (1 professional, 1 personal).

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Years Known \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relationship \_\_\_\_\_ Years Known \_\_\_\_\_

8. Do you possess a valid driver license?  Yes  No
9. Has your driver license ever been suspended or revoked?  Yes  No
10. Have you ever been convicted of a felony?  Yes  No

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

11. Have you ever had a license to provide health care revoked, limited, modified, or suspended?  Yes  No
12. Have you ever had any disciplinary action taken against your license to provide health care?  Yes  No
13. Have you ever had any criminal conviction related to:
- a) Any federal health care program, including Medicare and Medicaid?  Yes  No
  - b) Patient neglect or abuse?  Yes  No
  - c) Health care fraud?  Yes  No
  - d) Use of a controlled substance?  Yes  No
  - e) Fraud, theft, embezzlement?  Yes  No
  - f) Breach of fiduciary responsibility or other financial misconduct?  Yes  No
  - g) Obstruction to a health care investigation?  Yes  No

**PLEASE READ:**

The facts set forth in my volunteer application are true and complete. I understand that if accepted in a volunteer role, false statements or omissions on this application will result in revocation of my volunteer status.

Permission is hereby given to Hearts for Hospice to investigate previous employment, educational background and references. I release Hearts for Hospice and former employers from any liability resulting from any lawful information provided which may result in termination of my volunteer status.

I understand that Hearts for Hospice has a policy requiring that a background check be completed on all volunteers and will be done upon completion of the Volunteer Training Program at no cost to me. I agree to provide any additional information necessary to complete the background check.

I understand that Hearts for Hospice has a policy prohibiting conflicts of interest or improper use of proprietary information which prohibits any release or use of Company property that would interfere with the business interests or operations of Hearts for Hospice.



I understand that my volunteer status may be terminated at any time by either Hearts for Hospice or myself with or without cause.

Volunteer Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

What would you personally like to gain from your volunteer work?

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What might be the most challenging or difficult aspect of your volunteer work?

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What do you anticipate are some of the issues our patients and families face?

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How do you handle stressful situations?

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Would you rather work in a one-on-one setting or a group environment?

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What accommodations should we make for your volunteer service (allergies, disabilities, etc.)?

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What method of transportation will you use for your volunteer work? \_\_\_\_\_

What do you see yourself doing in your volunteer role?

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Do you have any talents, skills, hobbies, or interests that you would like to share with a patient?

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