

Parkview Hospice Volunteer
Application

Name: Miss / Ms. / Mrs. / Mr. _____
Preferred Nickname: _____ Cell Phone Number: (____) _____
Home Phone Number: (____) _____ Work Phone Number: (____) _____
Home Mailing Address: _____
City: _____ State: _____ Zip Code: _____
E-address: _____
Work mailing Address: _____
City: _____ State: _____ Zip Code: _____
Your birth date: ____/____/____ Your Social Security Number ____-____-____

Emergency Contact:

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: (____) _____ Work Phone Number: (____) _____

Why Do You Want To Be a Hospice Volunteer?

Volunteer Experience:

Do you have volunteer experience? If so, where? _____

Dates of volunteer experience: _____

Types of duties: _____

Are you currently volunteering: Yes No If so, how many hours: _____

Hospice volunteers are asked to volunteer an average of 4 hour per week. You need to make a commitment to volunteer for a minimum of one year.

Types of service:

The categories listed are general and not inclusive of all possible duties. Please mark those that interest you.

_____ Home Visitor/Bereavement _____ General Office/Errands

_____ Spice of Life Volunteers are not allowed to be alone with patients. They may have a special skill to share like house cleaning, doing mending, or yard work. They also help the office by running errands or with fundraising events.

Skills

Please list any skills in which you are experienced and would be willing to share with us (E.g.: typing, computers, sewing, etc.): _____

References

(Other than relatives, please. If employed, please give us one work reference and one personal reference.)

1. Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to this person: _____

2. Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to this person: _____

PERMISSION FOR CRIMINAL HISTORY CHECK

I understand that a Criminal History Check must be done on all Parkview Home Health & Hospice staff before they are allowed to represent Parkview in any capacity. I give permission for Parkview to obtain a Criminal History Check on me.

Full Name-printed (as it appears on Social Security Card)

Social Security # _____ - _____ - _____

CONFIDENTIALITY AGREEMENT FOR VOLUNTEERS

I understand that while performing my volunteer duties at Parkview Home Health & Hospice I have access to verbal, written, filmed and recorded hospital and patient information. I understand that this information can only be shared with those who need to know it to do their job. I must keep this information confidential at all times both during volunteering and when with family, friends and others in the community.

I understand that I may receive disciplinary action, including dismissal from volunteer duties or legal action, if I violate this confidentiality pledge.

If I am accepted as a Hospice Volunteer, I will fulfill my commitment of service and observe all policies and procedures for volunteers. I guarantee by my signature that I have been informed of Parkview's confidentiality policy concerning private information and its treatment.

Applicant's Signature _____ Date _____

Witness's Signature _____ Date _____