

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: _____
Birth date: ____/____/____ 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 volunteer
_____ General Office/Errands volunteer
_____ Spice-of-Life volunteer partners with a Parkview Hospice staff member during patient visits. They share a special skill like house cleaning or performing yard work. Volunteers also help with fundraising for events.
_____ Vet-to-Vet volunteer

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 (non-family members)

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 _____