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 _____-_____-_____
We have a Vet To Vet program where veterans visit veterans that are patients. Are you a veteran? No Yes If Yes, what branch of the service

_____

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 with fundraising 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 - Other than relatives

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 _____