VOLUNTEER APPLICATION VL-F-16	
Action	**Date**
Approved	
Reviewed	
Revised	
Policy Number	

Name: _____

Address: _____ City _____ Zip Code: _____

Phone: Home _____ Work_____ Cell _____

E-mail: _____ Fax:_____

Employer: _____ Occupation: _____

Employer's Address: _____

Education: _____ Civic/Professional membership: _____

Marital Status:_____Spouse Name: _____

Social Security #: _____Drivers License #: _____

Language(s) Spoken other than English: _____ Date of Birth: _____

Other Special Skills/Training: _____

_____

Please answer the following questions

1. Are you a veteran? ☐ Yes ☐ No
2. How did you learn about Arkansas Hospice? _____
3. Are you familiar with the philosophy and concept of hospice care? ☐ Yes ☐ No
4. In which capacity do you wish to volunteer?

☐Direct Patient Care ☐Bereavement ☐Phone Reception ☐Office Work
☐Fund Raising ☐Data Input ☐Available as Interpreter ☐ Other

Available Hours per week_____ ☐Days ☐Evenings ☐Weekends

Please share any life experiences or personal characteristics that especially qualify you for hospice work:

_____

_____

_____

Emergency Contact Name/Number: _____

2nd Emergency Contact Name/Number: _____

_____ _____
Signature Date

PERSONAL REFERENCES:

Name: _____ Name_____
Address:_____ Address _____
Occupation_____ Occupation _____
Phone:_____ Phone _____
Relationship:_____ Relationship _____

Name:_____
Address:_____
Occupation_____
Phone:_____
Relationship _____

FOR OFFICE USE ONLY

Proof of Insurance: _____Yes _____No
Comments:_____

Volunteer Training
Date/Trainer_____

Reference #1 Checked____
Comments_____

Reference #2 Checked____
Comments_____

Reference #3 Checked____
Comments_____