

Hospice Volunteer Application

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

E-Mail: _____ Date of Birth: ____/____/____

May we mail information to you? Yes No

Do you drive? Yes (name of auto insurance company is required) No

Auto Insurance Company: _____

Employer: _____

Supervisor's Name: _____ Work Phone: (_____) _____

Emergency Contact Information

Name: _____ Relationship: _____

Emergency Phone: (_____) _____ Evening Emergency Phone: (_____) _____

Education

Are you currently enrolled in school? Yes (name of school is required) No

Name of School: _____ Grade: _____

Extracurricular Activities: _____

I have completed:

High School GED Some College College/University Graduate School

Career Interests: _____

Volunteer Service Information

Is volunteer service required for your school or community group? Yes No

Type of Service Project:

- Practicum
- Internship
- Community Service

Service Project Start Date: _____ End Date: _____

Total Hours Required: _____

Project Supervisor's Name: _____

Supervisor's Daytime Phone: (_____) _____

Prior Volunteer Experience

Organization # 1
Organization Name: _____
Type of Service: _____ Length of Service: _____
Supervisor's Name: _____

Organization # 2
Organization Name: _____
Type of Service: _____ Length of Service: _____
Supervisor's Name: _____

Organization # 3
Organization Name: _____
Type of Service: _____ Length of Service: _____
Supervisor's Name: _____

Employment History

Company #1
Company Name: _____
Your Job Title: _____
Duties: _____
Supervisor's Name: _____
Dates Employed: _____

Company #2
Company Name: _____
Your Job Title: _____
Duties: _____
Supervisor's Name: _____
Dates Employed: _____

Company #3
Company Name: _____
Your Job Title: _____
Duties: _____
Supervisor's Name: _____
Dates Employed: _____

Volunteer Availability

- All Year
- Part of Year: _____
- Summer Only
- Weekday Mornings
- Weekday Afternoons
- Weekday Evenings
- Weekends

Opportunities for Adult Volunteers

- Visiting Adult Patients
- Visiting Pediatric Patients
- Visiting Nursing Home Patients
- Bereavement Support to Families
- Office Work
- Crafts
- Fund-Raising

Opportunities for Junior Volunteers

- Memory Videos
- Scrapbooking
- Visiting Pediatric Patients
- Visiting Healthy Children in a Patient's Home
- Running Errands for Patients
- Visiting Nursing Home Patients
- Reading to Patients
- Office Work
- Special Events
- Bereavement Camp

Hobbies, Skills and Languages Spoken: _____

What problems, if any, do you foresee in doing hospice work? _____

Briefly describe previous losses, through death, of loved ones.
Please include relationship to you and cause of death. _____

When did these losses occur, and where are you in the grieving process? _____

How did you hear about BJC Hospice? _____

Have you ever been convicted of, or plead guilty to, a crime, excluding misdemeanors and summary offences? Yes No

If yes, please explain. _____

I verify this information is true and correct to the best of my knowledge, and I authorize release of information to BJC Hospice for the information requested on this application.

Signature _____ Date _____

If minor, signature of parent or guardian:

Signature _____ Date _____

Mail to: BJC Hospice
Attn: Volunteer Department
9890 Clayton Road, Suite 220
St. Louis, Missouri 63124