

KINDRED HOSPICE VOLUNTEER APPLICATION



PLEASE READ BEFORE COMPLETING THIS APPLICATION

This company does not discriminate in the recruitment, hiring, and conditions of employment (*volunteering*) on the basis of race, color, religion, national origin, sex, disability, age, or veteran status and any other applicable laws. Your completed application will be reviewed carefully. However, applying for Volunteer opportunities does not guarantee acceptance into this program. Volunteer consideration necessitates that you meet all minimum qualifications and requirements for the applied position.

PERSONAL DATA

Name _____ Phone/ Cell # _____

Street Address _____ City, State, Zip _____

Email _____

Employer _____ Full Time Part Time

Employer Address _____ Business Phone # _____

Emergency Contact _____ Phone/Cell # _____

Are you over the age of 18? YES NO If NO, are you at least 16 years of age? YES NO

GENERAL INFORMATION

How were you referred to our company? _____

Specific name of referral source indicated above, if applicable: _____

When are you available to volunteer? Weekday Weekend(s) School Year Other _____

Do you have access to reliable transportation? YES NO

Have you ever pleaded guilty to or been convicted of a criminal offense? YES NO

• If yes, give dates and circumstances _____

Are you currently, or have you ever been, suspended, debarred or otherwise excluded from participation in any federal or state health care program? YES NO

Have you ever been involuntarily discharged from a position, paid or Volunteer? YES NO

• If yes, give dates and circumstances _____

CONVICTIONS: *A conviction does not automatically mean you will be unable to volunteer. What you were convicted of, the circumstances surrounding the conviction and how long ago the conviction occurred are all important considerations in determining your eligibility. Please share all the facts to ensure a fair decision process.*

EDUCATION

High School Associate's Degree Some College Bachelor's Degree Master's Degree Post Graduate Other _____

PREVIOUS VOLUNTEER EXPERIENCE

Organization _____ Type of Work _____

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REFERENCES (Professional or personal)

Name	Address	Phone/Cell #	Relation	Time Known

VOLUNTEER POSITION PREFERRED (Please check boxes of interest and then circle items of interest underneath)

PATIENT SUPPORT

- Companionship/ socialization/ caregiver relief
- Assistance with meal preparation/ light household chores
- Spiritual/ bereavement/ emotional support
- Vigil Volunteering (sitting with and attending to our actively dying patients)
- Veteran Volunteers
- Pet therapy (requires certification of therapy animal)
- Massage therapy (*requires* licensure within the State of practice)
- Enrichment services (music/ art)

ADMINISTRATIVE SUPPORT (Data entry, filing, copying, assistance with mailings, etc)

OTHER: _____

Do you speak a foreign language? YES NO Specify _____

Are you an active service member/ Veteran? YES NO Specify _____

Other skills and interests? _____

CODE OF ETHICS FOR VOLUNTEERS

As a Volunteer, I realize I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume accountability for my work and will seek to fulfill my responsibilities to the best of my ability. I understand that any information disclosed to me while assisting Kindred Hospice is confidential. I interpret my role as Volunteer to mean that I have agreed to work without monetary compensation. Having been accepted as a Volunteer, I will do my work according to the standards set forth in the Volunteer Orientation Manual and description. I agree to a background investigation.

DECLARATION

I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that by submitting this application and consenting for a background investigation I am authorizing inquiries to be made concerning my employment, character, and public records for the sole purpose of determining my suitability as a Volunteer. I affirm that I have read the Volunteer Code of Ethics and agree to abide by its regulations. I agree to respect the confidentiality of any patient or family in the course of my Volunteer activities with Kindred Hospice.

Print Name _____

Signature _____

Date _____