



# Hospice Community Volunteer Application

Name \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Languages Spoken \_\_\_\_\_

## Contact Information

Home Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please list best means/times to reach you \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cellular Phone/Beeper \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone(s) \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_

## Education, Employment and Specialized Training (professionals please attach resume)

Please describe your work experience

Have you ever been convicted of a crime excluding traffic violations? \_\_\_\_\_

If yes, please describe\*

\*A conviction record will not necessarily be a bar to volunteer service. Factors such as age at time of offense, seriousness and nature of offense, and rehabilitation will be taken into account.

Past volunteer experience(s)

Special Interests, Training, Skills, Hobbies

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### Availability to Volunteer

How many hours of volunteer service per week are you able to contribute? \_\_\_\_\_

How many months do you feel you could commit to our program? \_\_\_\_\_

**Are you interested in volunteering?**  with patients at home  in office  with patients on inpatient unit  
 education  intake/outreach  bereavement  other \_\_\_\_\_

**Have you personally experienced a life-threatening illness/situation?**  Yes  No

If so, please describe the effect on your personal attitudes and/or way of life

### Have you experienced the loss of a loved one through death or separation?

Within the past year?  No  Yes

If so, please briefly describe the circumstances

Other significant loss?

At this time, please identify any particular strengths and areas in need of improvement in yourself as you anticipate volunteering for MJHS patients and/or families?

Are you active in any other service-oriented groups? (Temple, Parish, Community, Mentoring etc.)?  Yes  No

Place \_\_\_\_\_ service \_\_\_\_\_ hours/months \_\_\_\_\_

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I understand that I will receive no financial compensation and that full participation in the hospice volunteer training program and additional training, as determined by the volunteer coordinator and/or designee, is a prerequisite to a volunteer assignment with a hospice patient.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

**Please save completed application and email to [HOSPVOL@mjhs.org](mailto:HOSPVOL@mjhs.org)**