

Whatcom Hospice

WHATCOM HOSPICE VOLUNTEER APPLICATION – LEVEL I

PLEASE COMPLETE ENTIRE FORM WITH AS MUCH DETAIL AS POSSIBLE. USE ADDITIONAL PAPER IF NECESSARY.

NAME: _____
NICKNAME: _____

ADDRESS: _____

CITY STATE ZIP

E-MAIL _____

PHONE: HOME _____ CELL _____ WORK _____

WHAT AREAS OF HOSPICE ARE YOU INTERESTED IN VOLUNTEERING? PLEASE CHECK ANY/ALL

- | | |
|---|--|
| <input type="checkbox"/> OFFICE SUPPORT | <input type="checkbox"/> DRIVER |
| <input type="checkbox"/> HOME MAINTENANCE | <input type="checkbox"/> GARDNER/LANDSCAPE SUPPORT |
| <input type="checkbox"/> OTHER: | <input type="checkbox"/> SEAMSTRESS / KNITTING |

WHEN COULD YOU BE AVAILABLE TO VOLUNTEER FOR HOSPICE? PLEASE CHECK ANY ON THE GRID BELOW.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
AM'S – 9-1							
PM'S – 1-5							
EVES - 5-9							
OTHER:							

1. HOW DID YOU HEAR ABOUT THE HOSPICE VOLUNTEER PROGRAM?
2. WHY DO YOU WANT TO BE A HOSPICE VOLUNTEER?
3. ARE YOU 18 YEARS OF AGE OR OLDER?
4. LIST SPECIAL SKILLS, ACTIVITIES, INTERESTS, OR HOBBIES YOU COULD SHARE WITH THE HOSPICE PROGRAM (PROFESSIONAL SKILLS, NOTARY, FOREIGN LANGUAGES, MUSIC, CREATIVE ARTS, ETC.):
5. EDUCATION: HIGHEST GRADE COMPLETED? _____ DEGREES/TRAINING/LICENSES _____
6. ARE YOU CURRENTLY A STUDENT? Y N FIELD OF STUDY: _____ WHERE? _____
17. ARE YOU CURRENTLY EMPLOYED? FULL-TIME _____ PART-TIME _____ OCCUPATION: _____

18. ARE YOU RETIRED? _____

19. WHAT KINDS OF JOBS HAVE YOU HELD IN THE PAST?

20. DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT WE SHOULD BE AWARE OF IN ASSIGNING YOU AS A VOLUNTEER? PLEASE EXPLAIN:

21. IN WHAT AREAS OF WHATCOM COUNTY WOULD YOU PREFER TO VOLUNTEER (BELLINGHAM, NORTH, WEST, EAST, SOUTH)?

22. ARE YOU WILLING TO TRAVEL TO OTHER AREAS OF THE COUNTY? Y N PLEASE SPECIFY:

23. DO YOU HAVE RELIABLE TRANSPORTATION? CAR? _____ BUS? _____ OTHER?

24. CAN YOU PARTICIPATE IN THE 5- HOUR TRAINING PROGRAM?

25. CAN YOU COMMIT TO AT LEAST ONE YEAR (FOLLOWING TRAINING) TO THE PROGRAM?

PERMISSION FOR RELEASE OF INFORMATION—VOLUNTEER REFERENCE CHECK

YOU MUST LIST THREE REFERENCES & PROVIDE COMPLETE MAILING ADDRESSES OR EMAIL. REFERENCES WILL BE CONTACTED. NO FAMILY. PROFESSIONALS OR FRIENDS ONLY WHO CAN ATTEST TO YOUR RELIABILITY.

1. NAME _____ OCCUPATION _____

ADDRESS _____

E-MAIL _____

PHONE _____

2. NAME _____

OCCUPATION _____

ADDRESS _____

E-MAIL _____ PHONE _____

3. NAME _____

OCCUPATION _____

ADDRESS _____

E-MAIL _____ PHONE _____

I DO HEREBY GRANT PERMISSION FOR THE ABOVE NAMED INDIVIDUALS AND/OR AGENCIES TO RELEASE INFORMATION TO WHATCOM HOSPICE CONCERNING MY CHARACTER, EMPLOYMENT, PERFORMANCE, SKILLS, COMPETENCE, AND/OR GENERAL ABILITY.

IT IS UNDERSTOOD THAT THIS PERMISSION INCLUDES CUMULATIVE AND CONFIDENTIAL INFORMATION, WHICH WOULD ASSIST WHATCOM HOSPICE IN FILLING VOLUNTEER POSITIONS.

AGREEMENT OF CONFIDENTIALITY: I UNDERSTAND THAT ANY INFORMATION I MAY OBTAIN DIRECTLY OR INDIRECTLY CONCERNING PATIENTS, DOCTORS OR PERSONNEL WHILE I AM A VOLUNTEER AT WHATCOM HOSPICE IS CONFIDENTIAL AND THAT THIS CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW.

SIGNATURE _____

DATE _____

**PLEASE RETURN TO: DIANNE GILLESPIE, VOLUNTEER COORDINATOR - E-MAIL:
DGILLESPIE@PEACEHEALTH.ORG**

**WHATCOM HOSPICE, 800 E. CHESTNUT ST., SUITE. 1-C, BELLINGHAM, WA 98225
FAX: 788-6884**

M:VOLTRNG/VOL APP-LVL I