

Dr. Bob Kemp Hospice Visiting Volunteer Application Form

Name _____

Phone (home) _____

Address _____

(work) _____

E-mail _____

Fax _____

Major Intersection _____

Quadrant _____

Employment _____

Student of _____

Retired _____

When are you able to volunteer? (check all that apply)

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preference: _____

Languages _____

Are you willing to provide transportation for clients during visits? (Liability insurance coverage of \$2,000,000 needed)

Brief Summary of Current/Previous Employment

Current/Previous Volunteer Experience

What skills and interests do you bring to your clients?

Training Date _____

What prompted your interest in Hospice palliative care?

What qualities do you feel you bring to Hospice volunteer work?

What do you expect to gain from your experience with the Dr. Bob Kemp Hospice?

The following is a list of Dr. Bob Kemp Hospice “Core Values”. In the space provided, write a *brief* phrase or sentence, indicating what each word means to *you*.

Dignity _____

Integrity _____

Compassion _____

Open Communication _____

Person-Centred Care _____

Have you experienced a significant personal loss in the past two years?

Do you have a strong support system in your life?

What methods do you use to cope with stress?

Do you have any health concerns that may affect your functioning as a visiting volunteer? Please specify any chronic conditions (e.g. back injuries) or allergies (e.g. animals, cigarette smoke).

Are there any other areas of support that would interest you as a volunteer for the Dr. Bob Kemp Hospice?

- Bereavement Programs
- Special Events / Fundraising / Public Relations
- Administrative / Computer / General Office Work
- Other _____

In case of emergency please call _____ ,

Phone _____ ; Relationship _____ .

Please read the following carefully before signing this application form.

I understand that the information provided in this application form is on permanent file with the Dr. Bob Kemp Hospice, will be kept confidential, and will be used only to assist in the Dr. Bob Kemp Hospice screening process and then in making the best possible match between myself and a client.

I also understand that upon acceptance as a volunteer with the Dr. Bob Kemp Hospice, I am committing to:

- a police reference check as part of the screening process.
- attending volunteer training and other educational sessions (e.g. monthly meetings) provided by Dr. Bob Kemp Hospice.
- abiding by the Dr. Bob Kemp Hospice Policies and Procedures.
- a commitment of 15 hours per month for a minimum of one year.
- the possibility that I may be assigned to the client program (home visiting, day, residential) most in need of support at any given time.

I hereby certify that the information in this application form is true and complete.

Applicant Signature _____

Date _____