



Dr. Bob Kemp Hospice Volunteer Application

Name: _____ Phone: (H) _____
 Address: _____ (W) _____
 _____ (C) _____
 _____ E-mail: _____

Employment History: (dates and description of work) Retired: _____

Volunteer Experience: (dates and description of work)

Special Skills/Interests/Other languages spoken:

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

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

Preference: _____

How did you hear about the hospice? _____

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

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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 _____

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 volunteer?
Please specify any chronic conditions (e.g. back injuries, allergies, cigarette smoke)

What area of support are you interested in? Please circle all that apply.

Residential Support	Holistic Therapies	Kitchen	Reception
Special Events/Fundraising/Public relations			Kitchen/Cooking/Baking
Administrative/Computer/General Office Work			Lawn Maintenance/Gardening
Bereavement Support	Day Hospice	Home Support	Drivers

Other _____

In case of emergency call: _____

Phone _____ Relationship _____

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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 placement for myself in an appropriate volunteer position.

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

- A police reference check and a vulnerable sector check as part of the screening process.
- Attending volunteer training and other educational sessions (e.g., monthly meetings) provided by the 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 or 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 _____