



Bringing Health Care Home

Hospice Volunteer Application

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ Zip _____

Home Phone () _____ Work Phone () _____

Cell Phone () _____ Email _____

Person to be notified in an emergency:

Name _____ Phone () _____

Address _____

City _____ Zip _____

Employer _____ Occupation _____

Can receive calls at work (please check one): Yes No Emergency Only

Education completed _____

Please list any Professional License, Certification, or Registration that you may have:

Type _____ Number _____

State(s) _____ Expiration Date _____

Are you a veteran? _____ If so, in what branch of service? _____

Education/Special Training (please list any training or experience relevant to hospice work)

Work Experience _____

Other special services/skills: (art, music, cultural studies, grant-writing or research, public relations, manicurist, hairdresser, masseuse, etc.)

Do you speak or have basic proficiency in any other languages? (If so, please list them here.)

Volunteer History (where, capacity of volunteer duties, length of service)

What do you look for in a volunteer experience?

How did you hear about our Hospice volunteer program?

Why do you want to be a hospice volunteer?

Do you have access to transportation?

_____ Yes _____ No

Death and Dying Awareness

Have you ever been with someone at the time of their death?

_____ Yes _____ No

If yes, please describe briefly:

Have you ever provided care to anyone who was dying?

_____ Yes _____ No

(If yes please explain)

Please list significant losses that have occurred in your life and your age at the time of each.

Availability to Volunteer:

Mornings Afternoons Evenings Weekdays Weekends

Specific availability: _____

Can you commit to volunteering a minimum of three hours per week for a year? ___ Yes ___ No

In what regions are you available to serve?

- | | |
|---|--|
| <input type="checkbox"/> Missoula City | <input type="checkbox"/> Polson area |
| <input type="checkbox"/> Missoula area (15 miles out) | <input type="checkbox"/> Seeley Lake area |
| <input type="checkbox"/> N. Bitterroot Valley | <input type="checkbox"/> Bonner-Drummond |
| <input type="checkbox"/> S. Bitterroot Valley | <input type="checkbox"/> St. Ignatius/Arlee area |
| <input type="checkbox"/> Superior area | <input type="checkbox"/> Other _____ |

Are you available to provide respite on occasion for extended periods (3-6 hours)? Yes No

Areas of Interest (Services you would like to offer)

Patient/Family Care (check all that apply & specify where appropriate)

- | | |
|--|--|
| <input type="checkbox"/> In Home <input type="checkbox"/> In Facility <input type="checkbox"/> | |
| <input type="checkbox"/> Companionship | <input type="checkbox"/> Transport patient (appts, shopping) |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Shopping/errands |
| <input type="checkbox"/> Pet therapy | <input type="checkbox"/> Lawn care/Snow shoveling |
| <input type="checkbox"/> Music - _____ | <input type="checkbox"/> Housekeeping |
| <input type="checkbox"/> Art - _____ | <input type="checkbox"/> Handyman/Carpentry |
| <input type="checkbox"/> Reiki | <input type="checkbox"/> Auto maintenance/Repair/Cleaning |
| <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Hair/Manicure/Pedicure |
| <input type="checkbox"/> Arts & Crafts - _____ | <input type="checkbox"/> Sewing/quilting |
| <input type="checkbox"/> Card games | <input type="checkbox"/> Board games |
| <input type="checkbox"/> Puzzles | <input type="checkbox"/> Scrap booking |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Photography |
| <input type="checkbox"/> Vigil service | <input type="checkbox"/> Outings |
| <input type="checkbox"/> Life Review | <input type="checkbox"/> Bible reading |
| <input type="checkbox"/> Other (please specify) _____ | |

Non-Patient Care (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Bereavement calls | <input type="checkbox"/> Fundraising |
| <input type="checkbox"/> Bereavement mailings | <input type="checkbox"/> Events |
| <input type="checkbox"/> Office/clerical | <input type="checkbox"/> Marketing |
| <input type="checkbox"/> Mailings | <input type="checkbox"/> Data entry |
| <input type="checkbox"/> Tree of Life | <input type="checkbox"/> Assist with trainings |
| <input type="checkbox"/> Other (please specify) _____ | |

Do you have any passions/interests that would be helpful for us to know about?

List two personal references (*excluding family members*).

Name _____

Phone () _____

City _____ State _____

Name _____

Phone () _____

City _____ State _____

Have you ever been convicted of a felony? _____ Yes _____ No

(If yes, please explain)

Please note that a background check and completion of volunteer training is required.

Thank you for your interest in volunteering for Partners Hospice! Please read, and sign below.

I certify that the information I provided in this **Hospice Volunteer Application** is true and complete to the best of my knowledge. I authorize Partners In Home Care, Inc. to contact my previous employers and other resources to investigate any of the facts set forth in this Application or resume. I specifically waive prior written notice of disclosure of any personnel record information, including disciplinary reports, letters of reprimand or other disciplinary action. In consideration of acceptance of my application, I release Partners In Home Care, Inc. and my previous employers of any claimed liability arising out of such response and disclosure.

Signed: _____

Date: _____

Please send this application to:

Katrina Mikiah, Volunteer Coordinator

mikiahk@partnersinhomecare.org

406-327-3657

Partners In Home Care Hospice

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