Deaconess Hospice
611 Harriet Street
Evansville, IN 47713
Phone 812-450-7021
Fax 812-450-7050

HOSPICE VOLUNTEER APPLICATION

Application Date

Personal Information

Last Name	First Name	Middle Initial
Cell Phone	Home Phone	Work Phone
Email Address		
Address		Apartment Number
City	State	Zip Code

Person to Notify in Case of Emergency

Last Name	First Name	Middle Initial
Relationship	Contact Phone Number	Alternate Contact Phone Number

Current Employer	
Business Address	
Occupation	
May we contact you at work? ☐ YES ☐ NO	
Are you a student? ☐ YES ☐ NO	If yes, school attending

Volunteer History, Work Experience, Special Interest/Hobbies/Skills/Training

Previous Volunteer Experience

_____

_____

Work Experience/Special Interest/Hobbies/Skills/Training

_____

_____

Do you have access to transportation? ☐ YES ☐ NO

Do you know a language other than English? ☐ YES ☐ NO

If yes, Language _____ ☐ Speak ☐ Read ☐ Write

If yes, Language _____ ☐ Speak ☐ Read ☐ Write

Have you had experience with Hospice? ☐ YES ☐ NO
If yes, please explain:

_____

_____

Have you experienced a personal loss within the past 12 months? ☐ YES ☐ NO

Days and Hours Available

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

Volunteer Areas of Interest

Patient/Family Care

☐ Visits In Home ☐ Visits in Nursing Home/Facility ☐ Personal Care ☐ Meal Delivery
☐ Craft Comfort Items ☐ Alternate Therapy

Bereavement

☐ Caller to Surviving Family ☐ Home Visits ☐ Support Group Co-Facilitator ☐ Donations ☐ Office/Clerical
☐ Special Events Planning (Memorial or Memory Services)

Non-Patient Services

☐ Fundraising ☐ Mailings ☐ Events ☐ Marketing ☐ Courier ☐ Office/Clerical ☐ Data Entry
☐ Reception Desk/Answering Phones
☐ In Patient Hospice Only - Up keep of physical surroundings, food donations for family kitchen

Personal or Professional References

Last Name	First Name	Contact Phone Number	
Address	City	State	Zip Code
Relationship			

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Address	City	State	Zip Code
Relationship			

I authorize the above persons to supply the requested information in the reference check for my application as a volunteer. I release the aforementioned from all liability in providing this information and in verifying information that I have provided through the application process.

I certify that all of the information supplied is accurate.

I wish to donate my services and understand there is no payment for services rendered under the Volunteer program. I understand that photographs may be taken from time to time for publications or other uses.

If accepted as a volunteer, I agree to serve according to regulations, policies and procedures of CHI Health at Home. I will respect patient right's and maintain confidentiality concerning patients and families and will not discuss confidential information that I might obtain through my volunteer assignments.

Printed Name_____

Signature_____

Date_____