**Volunteer Application**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last**  | **First** | **Middle** | **Nickname** *(optional)*      |
| **Address** | **City** | **State** | **Zip** |
| **Are you at least 18?** [ ]  Yes [ ]  NoIf no, please complete a *youth* volunteer application. | **Date of birth (mm/dd)** | **Email** |
| **Home phone** | **Work phone** | **Cell phone** |
| **Best way to contact you:** [ ]  Home [ ]  Work [ ]  Cell [ ]  Email | **Best time to contact you:**[ ]  Morning [ ]  Afternoon |
| **Person to notify in case of emergency**:Name       Relationship       Phone       |
| **How did you hear about volunteering with AdventHealth Hospice Care?** *(Check all that apply)*[ ]  Personal hospice experience [ ]  Community event[ ]  Hospice of the Comforter publication [ ]  Radio[ ]  Hospice of the Comforter web site [ ]  TV[ ]  Newspaper/community publication [ ]  Employee [ ]  Friend [ ]  Volunteer Name:       [ ]  Speaker or presentation [ ]  Other:        |
| **Is volunteer service required for your school or community group?** [ ]  Yes[ ] NoIf yes, please briefly explain:      |
| **Has anyone close to you died within the last 12 months?** [ ] Yes[ ] NoIf yes, please briefly explain:      |
| **Have you experienced any other significant loss within the last 12 months?** [ ] Yes[ ] No If yes, please briefly explain: |
| **Do you know anyone who has experienced hospice care?** [ ] Yes[ ] No If yes, please briefly explain:      |
| **Have you previously volunteered for a hospice?** [ ] Yes[ ] NoIf yes, name of hospice:       |
| **Why are you interested in volunteering for AdventHealth Hospice Care?**  |
| **What qualifications do you possess that would make you a good hospice volunteer?**  |
| **Have you had any volunteer experience other than for a hospice?**[ ]  Yes[ ]  No If yes, please briefly explain: |
| **Are you willing to volunteer for at least one year?**[ ] Yes [ ] No |
| **What are your areas of volunteer interest?****Patient/Family Care** *(Check all that apply)*[ ]  Befriending – *home visits* [ ]  Respite for caregiver – *home visits* [ ]  Light housekeeping[ ]  Befriending – *nursing facilities visits* [ ]  Yard work [ ]  Hair cuts *(license required)*[ ]  Hospice House – *inpatient care support* [ ]  Fix-it projects [ ]  Massage therapy *(license required)*[ ]  Errands/shopping [ ]  Pet therapy *(certifications and* [ ]  Vigil program – *patient/family support* [ ]  Filming/editing patient *Life Reflections* *immunizations required)***Bereavement Support** *(Check all that apply)*[ ]  Bereavement phone support [ ]  Kids Grief Camp [ ]  Memorial service**Non-Patient Services** *(Check all that apply)*[ ]  Administrative/office support *(M-F 8:30 a.m. – 5:00 p.m.)* [ ]  Donor relations[ ]  Computer skills: Word/Excel/PowerPoint/data entry[ ]  Special events/special projects/outreach events  |
| **We have a volunteer skills database and would like to include your information**.Please list skills and interests *(Examples: music, arts/crafts, career/professional skills)*      |
| **Do you speak a foreign language?** [ ]  Yes [ ]  No If yes, what languages do you speak?       |
| **When are you available?** [ ]  Morning [ ]  Afternoon [ ]  Evening [ ]  Weekend [ ]  Flexible [ ]  Seasonal       **Best days for you to serve:** [ ]  S [ ]  M [ ]  T [ ]  W [ ]  TH [ ]  F [ ]  S **How many hours per week?**      \_\_\_**Are you available on short notice for temporary assignments?** [ ]  Yes  [ ]  No |
| **In what geographic areas are you willing to serve?** *(Check region)*[ ]  North: Sanford, Lake Mary[ ]  Central: Casselberry, Longwood, Altamonte Springs, Winter Springs, Winter Park[ ]  East: Oviedo, UCF area, Valencia Community College East area, Waterford Lakes, Avalon Park, Chuluota, Geneva[ ]  West: Apopka, Ocoee, West Orlando, Windermere, Winter Garden, Pine Hills[ ]  South: Kissimmee, St. Cloud, Downtown Orlando, South Orlando, Lockhart |
| **How far are you willing to travel to visit patients?**       miles **Do you have reliable transportation?**[ ] Yes[ ]  No |
| **Do you have a valid driver’s license?** [ ]  Yes[ ] No **Do you have auto insurance?** [ ] Yes[ ] No |
| **Do you have any medical problem, injury, physical limitations, chronic ailment, allergies or other condition that could affect your ability to perform volunteer work?** [ ] Yes[ ] NoIf yes, please specify:       |
| **Military experience****Are you a veteran?** [ ] Yes[ ] No**Which branch of the service? \_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **EMPLOYMENT HISTORY** |
| **Are you currently employed?** [ ]  Yes [ ]  NoWhat is/was your profession?       | **Retired?** [ ]  Yes [ ]  NoJob title |
| **If you are currently employed, please complete the following:**Place of Employment       Address       City       State       Zip       Phone (      )      Extension       Fax (      )      Email       What are your usual work hours?       May we contact you at work? [ ]  Yes [ ]  No |
| **Do you hold a professional license?** [ ]  Yes [ ]  NoIf yes, please complete: State       Type of license       License #       Expiration date       /      /       |
| **Does your employer match your volunteer time with a charitable donation?** [ ]  Yes [ ]  No [ ]  Don’t know |
| **EDUCATION INFORMATION** |
|  | Course of study/major | Please check last grade completed |
| High School |       |  [ ]  1 [ ]  2 [ ]  3 [ ]  4 |
| College/University |       |  [ ]  1 [ ]  2 [ ]  3 [ ]  4 |
| Post Graduate |       |  [ ]  1 [ ]  2 [ ]  3 [ ]  4 |
| Other       |
| **PERSONAL REFERENCES**  |
| **Please list the names, addresses and phone numbers of two people whom you have known for at least 7 years.** **Please do not list relatives or family. References will be contacted as part of our screening process.** |
| 1. Name

      | Daytime contact number      |
|  Address       | Relationship      |
| 1. Name

      | Daytime contact number      |
|  Address       | Relationship      |
| **Have you ever been convicted, pleaded no contest to, or had adjudication withheld on a crime?** [ ] Yes[ ] NoIf yes, please specify for each crime the following: (a) details concerning the type of crime (b) date of the conviction, plea of adjudication; and (c) penalty imposed.       |
| **Have you ever been a defendant in a civil court action?** *(i.e. a civil wrong, assault, battery, fraud, etc.)*[ ] Yes[ ] NoIf yes, for each action please specify the following: (a) the nature of the civil action against you; and (b) the outcome of the action.  |
| **Have you ever received a citation for driving while intoxicated or lost your driver’s license?** [ ] Yes[ ] NoIf yes, please briefly specify the details:       |
| **NOTE: Convictions will not necessarily disqualify you from volunteering; however, convictions that fall within Hospice of the Comforter guidelines will disqualify you due to state and federal regulations.** |

|  |
| --- |
| **Application Acknowledgements** |
| ***Please place a check mark in the box after reading each section carefully.*** |
| [ ]  | I authorize AdventHealth Hospice Care to conduct a criminal background check.  |
| [ ]  | I authorize AdventHealth Hospice Care to contact the two personal references I have listed. |
| [ ]  | I understand that I will need to complete a two step Tuberculosis screening test if I want to serve with patients and families and that I will need to update my TB screening annually. |
| [ ]  | I understand that if I am accepted as a AdventHealth Hospice Care volunteer, I must complete a volunteer training program before being given an assignment. I am willing to participate in ongoing training activities for volunteers. |
| [ ]  | I understand that I will need to participate in a volunteer interview and volunteer job placement process. |
| [ ]  | I understand I will need to provide time and activity reports each week. |
| [ ]  | As a volunteer, I understand that I am subject to a code of ethics similar to that which binds professionals in the field in which I work. I, like them, assume certain responsibilities and will be accountable for my actions in terms of what is expected of me.  |
| [ ]  | I agree to respect the confidentiality of any patient information I acquire in the course of volunteer activities with AdventHealth Hospice Care. |
| [ ]  | I agree to abide by all policies, regulations and guidelines established by AdventHealth Hospice Care. |
| [ ]  | I certify that all statements made on this application are true, complete and correct. I understand that any false information, omissions or misrepresentations of facts on this application will be cause for termination as a volunteer. |
| [ ]  | I understand that this application will not be considered if questions are left unanswered and if any of the Acknowledgements on this page remain unchecked. |

**I certify that answers given herein are true and complete**.

Signature (Typed name on emailed applications indicates signature.) Date

Thank you for your interest in becoming a volunteer with AdventHealth Hospice Care.

Once we have reviewed your application, we will contact you regarding an interview.

**Please either: Mail this application to Attn: Volunteer Services,**

**AdventHealth Hospice Care, 480 W. Central Pkwy., Altamonte Springs, FL 32714**

**Email to:** fh.hotc.volunteers@adventhealth.com