**Volunteer Application**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last** | | **First** | | | | **Middle** | | | | | | **Nickname** *(optional)* | |
| **Address** | | | | | **City** | | | | | | | **State** | **Zip** |
| **Are you at least 18?**  Yes  No  If 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?**  YesNoIf yes, please briefly explain: | | | | | | | | | | | | | |
| **Has anyone close to you died within the last 12 months?** YesNoIf yes, please briefly explain: | | | | | | | | | | | | | |
| **Have you experienced any other significant loss within the last 12 months?** YesNo If yes, please briefly explain: | | | | | | | | | | | | | |
| **Do you know anyone who has experienced hospice care?** YesNo If yes, please briefly explain: | | | | | | | | | | | | | |
| **Have you previously volunteered for a hospice?** YesNoIf 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?**  YesNo **Do you have auto insurance?** YesNo | | | | | | | | | | | | | |
| **Do you have any medical problem, injury, physical limitations, chronic ailment, allergies or other condition that could affect your ability to perform volunteer work?** YesNo  If yes, please specify: | | | | | | | | | | | | | |
| **Military experience**  **Are you a veteran?** YesNo  **Which branch of the service? \_**     **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | |
| **EMPLOYMENT HISTORY** | | | | | | | | | | | | | |
| **Are you currently employed?**  Yes  No  What is/was your profession? | | | | | | | | | **Retired?**  Yes  No  Job 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  No  If 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?** YesNo  If 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.)*YesNo  If 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?** YesNo  If 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](mailto:fh.hotc.volunteers@adventhealth.com)