

Date: _____

**APPLICATION FOR VOLUNTEER
HOSPICE OF THE SHOALS**

PERSONAL DATA

Last Name First Name Middle

Street Address

City State Zip

Previous Street Address

City State Zip

Home Phone () Business Phone () Social Security Number / /

Age: 18 or over? Yes No May we contact your present employer for a reference? Yes No

Have you ever been convicted of a felonious crime? Yes No If yes, explain in full. _____

Note: A conviction record will not necessarily bar an individual from volunteer service.

Service Position Desired (circle): Office/Clerical, Patient Care & Support, Fundraising, Speaker Date Available to begin

Schedule Preferred: Specify days (circle): Sun Mon Tues Wed Thurs Fri Sat Time of day or evening available:

Amount of time you would be willing to volunteer per week _____ hours.

Do you require any special assistance or equipment to do volunteer work? Yes No

If yes, indicate what is needed:

Have you ever been discharged or forced to resign from a position? Yes No If yes, explain: _____

Are you a U.S. citizen? Yes No If no, do you have a permit? Yes No

Do you have a reliable means of transportation? Yes No Driver's License Number _____
(Please provide a current copy of your card & car insurance)

Name and phone number of person to be notified in case of accident or emergency:
Relationship: _____ Telephone: _____

Do you speak other languages other than English, including sign language: _____

Have you ever been a caretaker or caregiver for a dying person? _____

Volunteer Experience (description and dates):

Preference time for training:

EDUCATION RECORD

Name and location of School	Graduated	Diploma/ Degree/ License
High School	Yes <input type="checkbox"/> No <input type="checkbox"/>	
College	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Vocational/ Technical	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Graduate School	Yes <input type="checkbox"/> No <input type="checkbox"/>	

SPECIAL SKILLS AND QUALIFICATIONS

Summarize special job-related skills and qualifications you are willing to share with the agency: _____

EMPLOYMENT HISTORY (List all employers, starting with present employer; attach resume, if necessary)* Include Military History

Employer		Address (City, State, Zip)	Phone No.	Supervisor
From (Mo./Yr.)	To (Mo./Yr.)	Position	Starting salary	Ending salary
Job Duties			Reason for Leaving	
Employer		Address (City, State, Zip)	Phone No.	Supervisor
From (Mo./Yr.)	To (Mo./Yr.)	Position	Starting salary	Ending salary
Job Duties			Reason for Leaving	
Employer		Address (City, State, Zip)	Phone No.	Supervisor
From (Mo./Yr.)	To (Mo./Yr.)	Position	Starting salary	Ending salary
Job Duties			Reason for Leaving	

REFERENCES (List three references not related to you)

Name of Employer	Phone No.
Address (City, State, Zip)	Contact Person
Name of Employer	Phone No.
Address (City, State, Zip)	Contact Person
Name of Employer	Phone No.
Address (City, State, Zip)	Contact Person

AUTHORIZATION FOR RELEASE OF PRE-VOLUNTEER INFORMATION

Name: _____ **Social Security Number:** _____

Date of Birth: _____

To be completed by all volunteer applicants. Please read carefully before signing.

I hereby affirm that the information contained in this application and in the accompanying resume, if any, is correct and complete to the best of my knowledge. I understand that any false statements, misrepresentations or omissions made by me on this application will be sufficient grounds for rejection of this application or discharge after service.

I hereby authorize Hospice of the Shoals to obtain pertinent information concerning me from former employers and schools to provide any relevant information that may be requested to arrive at a decision. I understand that as part of normal procedure for processing applications involve a routine iniquity, including general reputation, personal character and background check. I agree to such investigation and understand that I have the right to request the additional disclosures provided for in section 606 (b) of public law 91-508. I release all those providing or requesting such information from any liability that may arise by truthful disclosures or such investigations.

In the event that I become a volunteer of Hospice of the Shoals and select to serve in the home setting, I agree to submit to a TB skin test and accept if interested the hepatitis series before starting. I consent to such a test, and I request the examining doctor disclose to Hospice of the Shoals the results, which will remain confidential and segregated from my volunteer file. I understand that my continued service is contingent upon a negative TB Skin test.

If I am accepted as a volunteer, I will comply with all policies and procedures as set forth in the policy manuals, code of ethics, training classes and other materials of the Agency. I understand and agree that my service will be subject to termination, with or without cause, and with or without notice, at any time, at the option of either Hospice of the Shoals or myself.

Completion of this application by me or its receipt by Hospice of the Shoals does not indicate there are any volunteer opportunities open and does not in any way obligate the Agency.

Volunteer Applicant's Signature

Date