HOSPICE & PALLIATIVE CARECENTER
VOLUNTEER INFORMATION FORM

Name: ____ Date ______/______/______
(First) (Middle/Maiden) (Last)

Home Address: ____
(Street) (City/State) (Zip Code)

Mailing Address (if different): ____
(PO Box) (City/State) (Zip Code)

Home Phone: ( ) ______________________ Cell Phone: ( ) ______________________

E-mail: ____

Employer Name: ______________________________ Phone # : ( ) ______________
School (if student): ______________________________ Phone # : ( ) ______________

Emergency Contact: ______________________ Relationship: ______________________
Contact numbers: ____

Date of Birth: ________/________ Faith Community (*optional*): ______________________
(Month) (Day)

Have you experienced a death in your family, or someone close to you, in the past year? If so, who?

____

Have you served in the military? ____ If so, when and in what branch did you serve? ______________

Previous volunteer experience(s): ____

List any special skill(s) (ASL/foreign language, musical instrument, calligraphy, computer, etc.): ______________

____

How often are you available to volunteer? _____ weekly _____ monthly _____yearly

How did you hear about the Hospice volunteer program? ______________________________

Volunteer Opportunities (Please check areas of interest):

Patient/Family Contact (requires completion of 12-hours of training):
_____ Home Care _____ Hospice Home _____ Nursing Home _____ Notary Public
_____ Veterans _____ Transportation _____ Haircuts _____ Camp Carousel*
_____ Complementary Therapy* _____ Youth IMPACT* (Middle School to College)
(*Requires additional training and/or certification)

Administrative/Support Volunteers:
_____ Office Volunteers _____ Hospice Bakers _____ Hospice Bingo _____ Pantry Patrons
_____ Gardening _____ Sewing Circle _____ Holiday Helpers _____ KBR Pantry

Community Education: _____ Church Liaisons/Hospice Sabbath _____ Speakers Bureau _____ Health Fairs

Fundraising: _____ Hospice Hope Run _____ Light-Up-A-Life Ornaments _____ Fundraising Activities

Special Events: _____ Memorial Tree Service _____ Other areas of interest ______________________

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Acknowledgment of Confidentiality of Information
and
Consent for Photographs and/or Interview

In connection with my training, working in the Hospice office, patient/family involvement, team meeting attendance, or any other hospice-related activities or events:

I, ________________________________, hereby grant permission for photographs and/or interviews with Hospice & Palliative CareCenter to be used for public relations purposes.

In addition, I agree to hold all information I may have access to about Hospice patients/families confidential and will not divulge any information to unauthorized persons.

____
Printed Name

____
Signature

____
Street Address City State Zip

(____)____
Phone Number

____
Parent Signature if Under 18 Years of Age

____
Hospice Representative

____
Date

Please return the completed forms to: Volunteer Department, Hospice & Palliative CareCenter, 101 Hospice Lane, Winston-Salem, NC 27103