



VOLUNTEER APPLICATION

Last	First	Middle	Nickname <i>(optional)</i>
Address		City	State Zip
Are you at least 18? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If no, please complete a <i>youth</i> volunteer application.</small>		Date of birth (mm/dd)	Email
Home phone		Work phone	Cell phone
Best way to contact you: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Email		Best time to contact you: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	
Person to notify in case of emergency:			
Name		Relationship	Phone
How did you Hear About Doctors Hospice of Idaho <i>(Check all that apply)</i>			
<input type="checkbox"/> Personal hospice experience	<input type="checkbox"/> Community event		
<input type="checkbox"/> Hospice of the Comforter publication	<input type="checkbox"/> Radio		
<input type="checkbox"/> Hospice of the Comforter web site	<input type="checkbox"/> TV		
<input type="checkbox"/> Newspaper/community publication	<input type="checkbox"/> Employee <input type="checkbox"/> Friend <input type="checkbox"/> Volunteer	Name: _____	
<input type="checkbox"/> Speaker or presentation	<input type="checkbox"/> Other: _____		
Is volunteer service required for your school or community group? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please briefly explain:			
Has anyone close to you died within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please briefly explain:			
Have you experienced any other significant loss within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please briefly explain:			
Do you know anyone who has experienced hospice care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please briefly explain:			
Have you previously volunteered for a hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of hospice:			
What qualifications do you possess that would make you a good hospice volunteer?			
Have you had any volunteer experience other than for a hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please briefly explain:			
Are you willing to volunteer for at least one year? <input type="checkbox"/> Yes <input type="checkbox"/> No			

What are your areas of volunteer interest?

Patient/Family Care (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Befriending – home visits | <input type="checkbox"/> Respite for caregiver – home visits | <input type="checkbox"/> Light housekeeping |
| <input type="checkbox"/> Befriending – nursing facilities visits | <input type="checkbox"/> Yard work | <input type="checkbox"/> Hair cuts (license required) |
| <input type="checkbox"/> Hospice House – inpatient care support | <input type="checkbox"/> Fix-it projects | <input type="checkbox"/> Massage therapy (license required) |
| <input type="checkbox"/> Robison Residence – patient care support | <input type="checkbox"/> Errands/shopping | <input type="checkbox"/> Pet therapy (certifications and immunizations required) |
| <input type="checkbox"/> Vigil program – patient/family support | <input type="checkbox"/> Filming/editing patient Life Reflections | |

Bereavement Support (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Bereavement phone support | <input type="checkbox"/> Bereavement home visit | <input type="checkbox"/> Memorial service |
|--|---|---|

Non-Patient Services (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Administrative/office support (M-F 8:30 a.m. – 5:00 p.m.) | <input type="checkbox"/> Life.Art.Music Gala (annual) |
| <input type="checkbox"/> Computer skills: Word/Excel/PowerPoint/data entry | <input type="checkbox"/> Gift of Hope Breakfast (annual) |
| <input type="checkbox"/> Donor relations | <input type="checkbox"/> 1 Hour Inspirational Tour (monthly) |
| <input type="checkbox"/> 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)

- Ada County
- Canyon County
- Owyhee
- Elmore
- Gem

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 No

If yes, please specify:

EMPLOYMENT HISTORYAre you currently employed? Yes NoRetired? Yes No

What is/was your profession?

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 NoDo 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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
College/University		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Graduate		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

2. Name _____ Daytime contact number _____

Address _____ Relationship _____

Have you ever been convicted, pleaded no contest to, or had adjudication withheld on a crime? Yes No

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.) Yes No

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? Yes No

If yes, please briefly specify the details:

NOTE: Convictions will not necessarily disqualify you from volunteering; however, convictions

Application Acknowledgements

<i>Please place a check mark in the box after reading each section carefully.</i>	
<input type="checkbox"/>	I authorize Doctors Hospice of Idaho to conduct a criminal background check.
<input type="checkbox"/>	I authorize Doctors Hospice of Idaho to contact the two personal references I have listed.
<input type="checkbox"/>	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.
<input type="checkbox"/>	I understand that if I am accepted as a Doctors Hospice of Idaho volunteer, I must complete a volunteer training program before being given an assignment. I am willing to participate in ongoing training activities for volunteers.
<input type="checkbox"/>	I understand that I will need to participate in a volunteer interview and volunteer job placement process.
<input type="checkbox"/>	I understand I will need to provide time and activity reports.
<input type="checkbox"/>	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.
<input type="checkbox"/>	I agree to respect the confidentiality of any patient information I acquire in the course of volunteer activities
<input type="checkbox"/>	I agree to abide by all policies, regulations and guidelines established by Doctors Hospice of Idaho
<input type="checkbox"/>	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.
<input type="checkbox"/>	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 Doctors Hospice of Idaho.
Once we have reviewed your application, we will contact you regarding an interview.

**Mail this application to Attn: Volunteer Services,
Doctors Hospice of Idaho, 1550 Crestmont Drive #E, Meridain, Idaho 83642**