



306 Wharf Street ♦ P.O. Box 6042  
Brookings, OR 97415  
(800) 535-9472 ♦ Fax: (888) 611-8233  
Referral Fax: (866) 611-8843

## Volunteer Application

Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Street Address (If different than mailing): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Can you receive calls at work:  Yes  No  Emergency Only

Person to be notified in the case of an emergency:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Education/Special Training:

Work Experience:

Do you know a language other than English?  Yes  No

Language: \_\_\_\_\_  Speak  Read  Write

Language: \_\_\_\_\_  Speak  Read  Write

List Two Personal References (excluding family members). Please provide a complete address, as references are verified by mail.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Do you have access to transportation?**  Yes  No

Driver License, State and Number: \_\_\_\_\_  
Insurance Company and Policy Number: \_\_\_\_\_

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**Can you work in a smoke filled environment?**  Yes  No

Yes, with limitations:  Less Than 1 Hour  1-2 Hours  2-4 Hours  Up to 6 Hours

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**Do you have any physical limitations?**  Yes  No Explain briefly:

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**What days are you available?**

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

**What times are you available?**

Early Mornings  Mornings  Afternoon  Evenings  Late Night

**What locations would you like to serve in?**

Harbor  Brookings  Pistol River  Gold Beach  Wedderburn  
 Ophir/Nesika Beach  Agness  Port Orford  Langlois

How many miles from the above locations will you drive? \_\_\_\_\_ miles

How many miles inland will you drive? \_\_\_\_\_ miles

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**Identified Areas of Interest:** Please check all that apply.

- |   |   |                                    |   |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Respite for caregiver  | <input type="checkbox"/> Plumbing         | <input type="checkbox"/> Pet care  | <input type="checkbox"/> Caller                     |
| <input type="checkbox"/> House Painting         | <input type="checkbox"/> Writing Letters  | <input type="checkbox"/> Yard Work | <input type="checkbox"/> Life historian – scrapbook |
| <input type="checkbox"/> Life historian - video | <input type="checkbox"/> Reading          | <input type="checkbox"/> Moving    | <input type="checkbox"/> Light Housekeeping         |
| <input type="checkbox"/> Assisting with Mail    | <input type="checkbox"/> Companionship    | <input type="checkbox"/> Laundry   | <input type="checkbox"/> Minor House Repairs        |
| <input type="checkbox"/> Meal Preparation       | <input type="checkbox"/> Errands/Shopping | <input type="checkbox"/> Carpentry | <input type="checkbox"/> Meal Delivery              |
| <input type="checkbox"/> Cards/games            | <input type="checkbox"/> Other: _____     |                                    |   |

**Bereavement Support:**

- Home Visits     Vigil Team     Support Group     Phone Calls     Admin

**Help with Fundraising Events.**

- Yes     No

**Complementary Programs:**

- |   |  |                                       |                                     |
|---|--|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Instrumental Music Therapy | <input type="checkbox"/> Arts & Crafts | <input type="checkbox"/> Pet Visits   | <input type="checkbox"/> Manicurist |
| <input type="checkbox"/> Hairdresser                | <input type="checkbox"/> Reiki         | <input type="checkbox"/> Other: _____ |                                     |

**Community Outreach:**

- Events     Speaker     Carpentry     Photography     Writing PR  
 Sewing     Distribute Materials to Doctor Offices

**Agency:**

- Special Projects     Board Member

**Administrative/Clerical:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Answering phone | <input type="checkbox"/> Newsletter writing  | <input type="checkbox"/> Newsletter mailing | <input type="checkbox"/> Grant Writing    |
| <input type="checkbox"/> Data entry      | <input type="checkbox"/> Distribute Material | <input type="checkbox"/> General mailing    | <input type="checkbox"/> Filing/Reception |
| <input type="checkbox"/> Copying         | <input type="checkbox"/> Courier             | <input type="checkbox"/> Shredding          | <input type="checkbox"/> Transportation   |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Other areas: _____  |   |   |

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How did you hear about our Hospice volunteer program?

Why do you want to be a Hospice volunteer?

What qualities (skills, talents, knowledge, and experiences) do you feel you can incorporate into your Hospice volunteer work?

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**Death and Dying**

What are your thoughts and feelings about death?

Have you ever been with someone at the time of his or her death?  Yes  No

If yes, please describe briefly:

Have you ever provided care to anyone who was dying?  Yes  No (if yes, please explain):

When thinking of your own death, what words best describe death to you?

- I do not think about my own death       Sorrowful       Natural       Frightening  
 Painful       Lonely       Joyful       Heavy       Peaceful       Dark  
 Other: \_\_\_\_\_

Comments:

## Volunteer Principles of Confidentiality

Since even the identity of Hospice patients/families is confidential information, referring to patients/families by name should only occur within the hospice team.

- Discussion regarding patients/families must be held in private settings where others cannot overhear, and never in public places.
- Confidential information shared between the Hospice volunteer and Hospice patients/families must never be divulged to other family members or family/patient friends.
- Consultation with Hospice staff is required to ensure the most appropriate assistance to Hospice patients/families.
- When in doubt about confidentiality issues, always contact the volunteer coordinator or other Hospice Team members (nurse, social worker, chaplain) for clarification or assistance.

*Note:* Confidentiality exceptions include cases where the patient/family have shared that they either have or plan in the future to hurt themselves or others. *Please review these exceptions with your volunteer coordinator.*

## Code of Ethics for Volunteers

As a volunteer, I realize that I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume certain responsibilities and expect to account for what I do in terms of what is expected of me. **I understand that any patient/family case information that is disclosed to me while assisting the Hospice is confidential.** I interpret “volunteer” to mean that I have agreed to work without compensation in money but having been accepted as a volunteer worker, I expect to do my work according to standards set forth in the Volunteer Policies and Procedures.

## Declaration

I hereby certify that statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application, I authorize inquiries to be made concerning my employment and character for the purpose of determining my suitability as a volunteer. **I affirm to have read the above Code of Ethics for Volunteers and agree to abide by its regulations. I agree to respect the confidentiality of any client information I may acquire in the course of my volunteer activities.**

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Applicant Signature

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Date