

**HOSPICE OF CHARLES COUNTY, INC.
VOLUNTEER APPLICATION**

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ E-Mail: _____

Emergency Contact/Phone #/Relationship: _____

Type of volunteer position applying for (*check all that apply*):

Patient Care Bereavement Administrative Support Undecided

EMPLOYMENT HISTORY

Dates of Employment: _____ to _____

Employer: _____ Position: _____

Address: _____ City: _____ State: _____ Zip: _____

Supervisor: _____ Phone #: _____

Description of Work: _____

Dates of Employment: _____ to _____

Employer: _____ Position: _____

Address: _____ City: _____ State: _____ Zip: _____

Supervisor: _____ Phone #: _____

Description of Work: _____

EDUCATION

<u>Schools Attended</u>	<u>Diploma/Degree Received/Date</u>	<u>Course/Major</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

VOLUNTEER HISTORY

<u>Organization</u>	<u>Dates</u>	<u>Description of Work</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please send the completed form to the Volunteer Coordinator at:
 fax: (301) 861-5317
 mail: Hospice of Charles County, 2505 Davis Road, Waldorf MD 20603
 email: sloomis@hospiceofcharlescounty.org

QUALIFICATIONS

Time available for volunteer work (*check all that apply*): Weekdays Weekends Evenings

Why do you want to be a Hospice volunteer? _____

How would you describe your health in the past year (check one):

- Excellent Good Fair Poor

Do you have any physical or emotional restrictions which might affect your volunteer placement with Hospice? If so, please explain.

Have you experienced a death in your family or of a close friend in the last year? Yes No

Are you bi-lingual? Yes No If yes, what languages: _____

Do you have a valid driver's license? Yes No Do you have car insurance? Yes No

Do you have access to a car? Yes No

SPECIAL SKILLS

Office Skills: _____

Arts/Crafts: _____

Music (read/play instruments): _____

Practical Skills: _____

REFERENCES

Name: _____ Phone#: _____

Occupation: _____ Relationship: _____

Name: _____ Phone#: _____

Occupation: _____ Relationship: _____

Name: _____ Phone#: _____

Occupation: _____ Relationship: _____

How did you hear about Hospice? _____

COMMITMENT: I am willing to make a minimum one year commitment as an active volunteer.

Signature: _____ Date: _____