Allina Health
Home Care Services

VOLUNTEER APPLICATION

Full Name of Applicant: (First)_____(Middle**)_____(Last)_____

Nickname:_____Birth date**:_____ Gender**:_____

Street Address: _____City/State/Zip: _____

Mailing Addess (if different): _____

E-Mail: _____ Home Phone ( ) _____

Work Phone ( ) _____ Cell Phone ( )_____

Employer: _____ Occupation: _____

Can receive calls at work: [ ] Yes [ ] No [ ] Emergency only ****Required for background check.**

Allergies:_____

Person to be notified in an emergency:

Name: _____ Phone: ( ) _____

Address: _____ City: _____ Zip: _____

_____

Work Experience: _____

_____

IDENTIFIED AREAS OF INTEREST: *(Indirect patient volunteer work does not require 8-12 hour education course.)*

Patient/Family Care

[ ] In Home [ ] In Nursing Home [ ] Transportation [ ] Errands [ ] Alternative Therapies

Bereavement

[ ] Caller [ ] Home Visits [ ] Support Group Co-Facilitator [ ] Transportation [ ] Office/Clerical [ ] Memorial Service Committee

Non-Patient Services

[ ] Clerical [ ] Fundraising [ ] Mailings [ ] Events [ ] Marketing [ ] Data Entry

Language: _____ [ ] Speak [ ] Read [ ] Write

Other special services: (manicurist, hairdresser, masseuse, etc.)_____

Are you willing to drive up to 20 miles to visit a patient? [ ] Yes [ ] No

Specific areas willing to drive._____

REFERENCES: Please list two personal (non-family) references. We will contact them as part of determining your suitability as a volunteer in our program.

1 – Name:_____ Relationship:_____

Address: _____City/State/Zip: _____

Phone ( ) _____ Phone ( )_____

2 – Name:_____ Relationship:_____

Address: _____City/State/Zip: _____

Phone ( ) _____ Phone ( )_____

Have you had a member of your family die within the past 12 months? If so, please state your relationship to the individual.

_____

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?

_____

_____

DEATH & DYING

What are your thoughts and feelings about death? _____

_____

_____

Have you ever been with someone at the time of their death? [ ] Yes [ ] No

If yes, please describe briefly: _____

Comments: _____

_____

AVAILABILITY

Please indicate the days and times you are usually available to volunteer. We ask our volunteers be available from one to four hours a week.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Morning:	___	___	___	___	___	___	___
Afternoon:	___	___	___	___	___	___	___
Evening:	___	___	___	___	___	___	___

CRIMINAL BACKGROUND CHECK

PLEASE PRINT CLEARLY your state driver's license or state identification number for the background check.

_____

Please list any alias you have used (i.e. maiden name).

_____

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 information that is disclosed to me while assisting Allina Hospice & Palliative Care is confidential.

I interpret "volunteer" to mean that I have agreed to work without compensation in money. If and when I'm accepted as a volunteer worker, I expect to do my work according to the standards set forth in the Volunteer Policies and Procedures.

DECLARATION

I understand and agree that submitting this application form does not automatically register me as an Allina Health Home Care Services volunteer, and that there may be certain qualifications I must meet, including the acceptance of established volunteer policies and procedures before I may begin volunteering.

I hereby certify that the 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, character and public records for the purpose of determining my suitability as a volunteer. I understand that I will undergo a criminal background check at no expense. I understand if I have patient contact I will receive a one-time immunization assessment provided by Allina Health Home Care Services. I affirm that I have read the volunteer Code of Ethics and agree to abide by its regulations. I agree to respect the confidentiality of any client information I acquire in the course of my volunteer activities with Hospice.

_____ _____

Applicant Signature Date