FAMILY HOSPICE

Volunteer Application

Name: _____ Date: _____

Address: _____ Phone: (H) _____

City: _____ Phone: (W) _____

State: _____ Zip Code: _____ Phone: (Cell) _____

Social Security Number: _____ Email: _____

Occupation: _____

Place of Employment: _____

Address: _____

Date of Birth: _____ Education: _____

Marital Status: (S) (M) (W) (D) Health Status: _____

Previous/Current Volunteer Activities: _____

_____

_____

How Much Time Can You Give to Hospice?

Hours per Week: _____ Days of Week: _____

From: _____ (am) (pm) To: _____ (am) (pm)

One Year: (Y) (N) Can you provide transportation? (Y) (N)

Type of Service Desired

Baking	_____	Fundraisers	_____
Computers	_____	Literature Distribution	_____
Filing	_____	Mailings	_____
Front Desk	_____	Patient Support	_____

Special talents you possess: _____

_____

_____