JOHNSON COUNTY
COMMUNITY HEALTH SERVICES
Home Health • Public Health • Hospice

Office Use Only
Date Received: _____

Hospice Volunteer Application

Personal Data (please print clearly):

_____ _____
Name (Last, First, Middle) Maiden Name (if applicable)

_____ _____ _____ _____
Street Address City State Zip Code

_____ __ / __ / __ _____ - __ - _____
Email Address Birthdate Social Security Number:

_____ _____ _____
Home Phone Cell Phone Work Phone

How did you hear of this volunteer opportunity?

_____

Emergency Contact Information (please print clearly):

_____ _____
Name Relationship

_____ _____
Primary Phone Number Secondary Phone Number

Area of Interest (check all that apply):

☐ Johnson County ☐ Lafayette County

Assignment Preference (check all that apply):

☐ Patient Care Volunteer ☐ Administrative/Office
☐ Bereavement Volunteer (specify special skills or abilities) _____
☐ Errand Runner ☐ Other (please specify) _____
☐ Junior Volunteer/Intern

Availability:

☐ Daytime ☐ Weekends
☐ Evening ☐ Overnight

Can you give 3-4 hours per week? ☑ yes ☐ no
If not, what is the amount of time you can expect to give? _____
Schedule Preferences and/or Comments: _____

_____

Education:

High School Diploma or GED? ☑ yes ☐ no

Highest Grade Completed: ☑ 10 ☐ 11 ☐ 12

Post High School Training (College, Technical School, Military, Certificates, etc)

_____

_____

Are you currently in school?

☐ Yes, full time ☐ Yes, part time ☐ No

Employment:

Are you currently employed? ☐ Full Time ☐ Part Time ☐ No

If yes, what is your job? _____

Place of Employment: _____

Current Work Schedule: _____

Experience:

What type of work have you done in the past?

☐ Nursing ☐ Teaching ☐ Counseling ☐ Other (please specify)

1. _____
2. _____

Have you done any volunteer work? ☐ Yes, currently ☐ Yes, in the past ☐ No

If yes, please specify: _____

Personal Qualifications:

Have you experienced any deaths in your family or of those close to you? ☐ Yes ☐ No

Please specify your relationship to the person(s) and when they died:

_____

Expectations:

What do you anticipate receiving from a volunteer experience with the Johnson County Hospice Program?

_____

_____

What do you feel you can give to the Johnson County Hospice Program through volunteering?

_____

_____

References (3 required, please provide complete addresses):

① _____

Name (Last, First, Middle)

_____

Street Address

_____ _____ _____

City State Zip Code

In what capacity and how long has this person known you?

_____

② _____

Name (Last, First, Middle)

_____

Street Address

_____ _____ _____

City State Zip Code

In what capacity and how long has this person known you?

_____

③ _____

Name (Last, First, Middle)

_____

Street Address

_____ _____ _____

City State Zip Code

In what capacity and how long has this person known you?

_____

Additional Information & Comments:

_____

_____

_____

The applicant accepts the following terms: As part of our commitment to quality and excellence, Johnson County Hospice will continue to maintain a safe, healthy environment for you by requiring all applicants to submit a Family Care Safety Registry Form. Please fill out the attached form and submit it with a photocopy of your social security card. The photocopy will be shredded after it is processed.

The foregoing statements are, to the best of my knowledge, true and correct. The Johnson County Hospice Program has my permission to obtain the data needed to support this application.

_____ _____

Signature *Date*

Volunteer opportunities are available to all qualified applicants without regard to race, color, religion, gender, national origin, sexual orientation, age or disability. Johnson County Hospice Program shall reserve the right to deny appointment of prospective volunteers as a result of the application, interview and/or training process.