HOSPICE of Redmond

Serving Bend | Redmond | Sisters | Powell Butte | Prineville | Crooked River Ranch | Terrebonne | Madras

Hospice & Transitions VOLUNTEER APPLICATION

732 SW 23rd
Redmond, OR 97756
541-548-7483

Toll Free:
1-877-244-0858

www.hospiceofredmond.org

Mission Statement:

Hospice of Redmond is committed to enhancing the quality of life for the terminally ill and their families.

Date _____/_____/_____

The Hospice & Transitions volunteer programs often receive requests for volunteers with specific skills or interests such as: the ability to speak a foreign language; carpentry skills; signing for the deaf; quilting; cooking and more.

The following in-depth application is designed to provide the information Hospice of Redmond needs to effectively match volunteers to patients and families.

ALL INFORMATION PROVIDED BY APPLICANTS IS CONFIDENTIAL

Personal Data

Name _____
Last First MI

Address _____
Street PO Box

City _____ST_____Zip_____

Phone ( )_____(H) ( )_____(B)

Cell: _____ Email: _____
(Business, cell # and Email information is optional)

Birthday: Month_____Day_____Year_____

Emergency Contact: Name_____

Phone(s) _____

Licensed Driver? ☐ Yes ODL #_____ ☐ No

Insurance Co._____Policy # _____

Social Security Number_____

What brings you to Hospice & Transitions? ☐ Personal Experience
☐ Friend ☐ Professional Contacts ☐ Newspaper ☐ Church
☐ Other _____

Are you a relative or friend of a Hospice patient or a Transitions client?
☐ Yes ☐ No

What do you consider the strongest attributes/skills that you will bring to our programs?

Why do you want to become a Hospice and/or Transitions volunteer?

What support systems do you have to help you through a Hospice or Transitions volunteer experience?

Have you experienced a personal loss in the past year? ☐ Yes ☐ No

If yes, please tell us about the loss:

What past life experiences do you feel will be helpful to you as a Hospice or Transitions volunteer?

Have you worked with dying patients either personally or professionally? ☐ Yes ☐ No

If yes, please explain:

Are you available to volunteer for at least one year following training?

What are your thoughts about working with patients near your own age and/or dying children?

Have you ever pleaded guilty to, or been convicted of a criminal offense; any arrest, indictment or charge for sexual offense or property crime; OR any disciplinary action taken by a health professional regulatory board or agency?

☐ YES ☐ NO If yes, please lists dates and circumstances_____

Areas of Involvement: Please check areas that interest you.

INDIRECT INVOLVEMENT:

PATIENT/FAMILY CARE

- ☐ Adults
- ☐ Children
- ☐ HIV/Aids patients
- ☐ Nursing Home, ALF,AFH
- ☐ Errands/Delivery
- ☐ Telephone Calls
- ☐ Volunteer on Call (weekends)
- ☐ Bereavement
- ☐ Respite
- ☐ Vigil
- ☐ Transitions
- ☐ Transportation/Driving
- ☐ Other _____

SPECIAL EVENTS

- ☐ Camp Sunrise (kids' grief camp)
- ☐ Festival of Trees
- ☐ Social Events
- ☐ Memorial Celebrations
- ☐ Other _____

- ☐ Fund raising
- ☐ Public Relations - Hospice Ambassador, community presentations, etc.
- ☐ Volunteer recruitment/training
- ☐ Assist with meetings, seminars, workshops & conferences
- ☐ Library and resource center maintenance
- ☐ Receptionist
- ☐ General maintainance
- ☐ Lawn & garden
- ☐ Computer work
- ☐ Cooking & baking
- ☐ Other_____

As a patient/family care volunteer, are you able to respond to last-minute requests?

Medicine/supply deliveries ☐ **Yes** ☐ **No**

Your patient only? ☐ **Yes** ☐ **No**

Any patient who lives near you? ☐ **Yes** ☐ **No**

Number of hours per week you might be available:_____

Are you available: ☐ Days ☐ Evenings ☐ Weekends

Would you prefer to work with another volunteer to provide back-up support?
☐ Yes ☐ No

Are you available on short notice for temporary assignments/respite?
☐ Yes ☐ No

Do you mind being around : Children ☐ Yes ☐ No; Animals ☐ Yes ☐ No;
Smokers ☐ Yes ☐ No

Your Profession/Interests/Hobbies

☐ Professional ☐ Farming/Ranching ☐ Teacher ☐ Forest Service ☐ Military ☐ Trade ☐ Musician
☐ Computer/Tech ☐ Accountant ☐ Homemaker ☐ Medical ☐ Construction ☐ Other_____

Religious Preference

Are you a church member?
☐ Yes
☐ No
If yes, which church?
_____

If no, do you have any religious preferences?
_____
_____

Activities

☐ Cards
☐ Games
☐ Sports
☐ Hunting
☐ Fishing
☐ Hiking/Walking
☐ Canoeing/Kayaking
☐ Traveling
☐ Other
_____
_____
_____

Skills/Talents/Interests

☐ Painting
☐ Writing
☐ Signing
☐ Reading
☐ Gardening
☐ Computer
☐ Other (please list)
_____
_____

☐ Animals
☐ Arts/Crafts
☐ Needlework
☐ Music
☐ History
☐ Woodworking
_____
_____

Do you have any physical limitations?
☐ **Yes** ☐ **No**
If yes, please explain:

Personal References: Please provide a complete mailing address with zip code.

Name_____Address_____Phone_____

Name_____Address_____Phone_____

Name_____Address_____Phone_____

All patient care volunteers MUST have yearly proof of a TB skin test in order to volunteer in patient homes. You will be given a TB skin test during training if you haven't been tested recently.
Date of your last TB test:_____ (Not applicable to non-patient care volunteers)

Hospice of Redmond STATEMENT OF CONFIDENTIALITY:

I understand that the condition, care and treatment of the patients and families of Hospice of Redmond must be held in strict confidence by all staff, volunteers and board members. This obligation of confidentiality must be carefully fulfilled not only regarding the information on the patient's charts and records, but also regarding confidential matters learned in the course of professional and/or volunteer duties. Under no circumstances may I discuss this information with anyone, even the patient's family or friends, unless I am authorized to do so. Moreover, I understand that confidentiality also extends to all programmatic and organizational information acquired in the course of serving as volunteer, staff or board member, to include, but not be limited to a) materials and programs developed and used by Hospice of Redmond, b) personnel information, c) patient/family data, d) financial or operational data. I agree that the above material is the property of Hospice of Redmond. All research projects shall be approved by both the Chairman of the Board and the Executive Director to assure that the project is consistent with the goals and operating plans of the organization, and to assure that all research is in the best interest of our patients and families. Any research conducted shall take into consideration the needs of patients and families and shall always protect their well-being. Hospice of Redmond, through the Chairman of the Board and the Executive Director, shall approve the publications to which research or other papers are submitted. Hospice of Redmond shall be reasonable in considering above requests and approval shall not be unreasonably withheld. I understand that the Executive Director and his/her designee shall be the official spokesperson for the organization, and the Chairman of the Board shall be the official spokesperson for the Board of Directors. I will neither disclose any information or materials to any persons who are not employees of Hospice of Redmond, nor will I copy or remove the same from the premises of Hospice of Redmond, nor will I use the same for my personal benefit or for the benefit of any other person or corporation other than Hospice of Redmond. I further understand that divulging any information without authority may be grounds for appropriate action, including dismissal.

Signature_____Name (please print)_____Date_____

BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION

Have you ever pleaded guilty to, or been convicted of a criminal offense; any arrest, indictment or charge for sexual offense or property crime; OR any disciplinary action taken by a health professional regulatory board or agency?

☐ YES ☐ NO If yes, please lists dates and circumstances:

_____

_____

Upon signing this form, I authorize the Hospice of Redmond to conduct a criminal background check.

I understand that no appointment can be finalized until a criminal background check has been performed, and I agree to furnish the required information. I understand that any information received by Hospice of Redmond as a result of this inquiry will be used only for its consideration and will be kept in confidence.

I understand that I have the right to be told if the information in my file has been used to deny my application for volunteering. Please complete all the following information:

Full name: _____

Please list **all** previous names and years used: _____

_____

Address: _____

City: _____ State: _____ Zip: _____

Please list **all** states you have resided in: _____

_____

Driver's license number: _____ State of issue: _____

Date of birth: _____ Place of birth: _____

Signature: _____ Date: _____