Hospice Of Gladwin Area, Inc.

VOLUNTEER APPLICATION – Please print or type

SECTION I

FULL NAME
_____

Home Telephone ( ) _____ Work or Cell Phone ( ) _____

STREET & MAILING ADDRESS
_____

CITY _____ STATE _____ ZIP
_____

EMAIL ADDRESS _____ BIRTHDAY _____/_____/_____ SEX M ____ F ____

CURRENT EMPLOYER _____

RELIGIOUS PREFERENCE*_____

DRIVERS LICENSE NUMBER _____

Have you ever been convicted of charges stemming from: (Please state yes or no.)

Euthanasia (mercy killing)? _____ Use/possession of an illegal drug or alcohol? _____ Theft? _____

EMERGENCY CONTACT
_____

RELATIIONSHIP TO YOU _____ TELEPHONE NUMBER
_____

FOREIGN LANGUAGE _____ UNDERSTAND_____ READ _____ SPEAK ____

SECTION II – EDUCATIONAL DATA (Indicate highest level attained)

HIGH SCHOOL 1 ___ 2 ___3 ___ 4 ___ COLLEGE 1 ___ 2 ___ 3 ___ 4 ___ DEGREE TYPE _____

GRADUATE STUDIES _____ DEGREE TYPE _____

PROFESSIONAL TRAINING
_____

SEMINARS/TRAINING IN DEATH EDUCATION _____

OTHER TRAINING
_____

SECTION III – EXPERIENCE WITH LIFE THREATENIING ILLNESSES

Have you any chronic health problems or disabilities? Yes _____ No _____ If yes, please explain _____

_____

Have you ever been seriously ill? _____ if yes, what was the cause of the illness?
_____

Has any family member/close friend had a serious illness? _____ Did it result in death? _____

If yes, who and how recently?
_____

Please comment on that experience
_____

_____

SECTION IV – REFERENCES

Name _____ Address _____

City, State, Zip _____ Phone _____

Name _____ Address _____

City, State, Zip _____ Phone _____

Name _____ Address _____

City, State, Zip _____ Phone _____

SECTION V – RATIONALE

In order to better acquaint us with yourself, please indicate your reasons for wanting to serve as a Hospice Volunteer.

Are you willing and able to participate in the Hospice Training Program (Approx. 20 hours?)?

I, THE UNDERSIGNED, ATTEST THAT THE INFORMATION ON THIS APPLICATION IS TRUE. I GRANT MY CONSENT FOR HOSPICE OF GLADWIN AREA TO CONTACT THOSE PERSONS LISTED AS PERSONAL REFERENCES AND CONDUCT A BACKGROUND CHECK.

Applicant's signature _____ **Date** _____

Please return this application as soon as possible to :

Executive Director
Hospice of Gladwin Area, Inc.
PO Box 557
Gladwin, MI 48624