Application Date: _____

HOSPICE
of Wilson Medical Center

Volunteer Application

Name: _____ **Date of Birth:** _____

Address: _____

Mailing Address (If Different): _____

Home Phone: _____ **Cell Phone:** _____**Work Phone:** _____

Email: _____

Emergency Contact:

Name: _____ **Relationship:** _____ **Phone Number:** _____

Address: _____

Primary Physician: _____ **Phone Number:** _____

Education Background:

Name of Instution	**Course of Study**
1. _____	_____
2. _____	_____
3. _____	_____

Employment History:

Name of Organization	**Dates**	**Position**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Volunteer History:

1. _____	_____
2. _____	_____
3. _____	_____

Special Skills, Professional Services, Interests or Hobbies: _____

_____

_____

_____

How did you hear about volunteer opportunities with Hospice of Wilson Medical Center? _____

_____

Why do you wish to become a Hospice of Wilson Medical Center Volunteer? _____

_____

Volunteer Areas of Interest:
□Patient Care Volunteer
□Clinical Support Volunteer
□General Support Volunteer
□On-Call Volunteer

Availability:
□ Weekdays
□ Weeknights
□ Weekends

Hours per week to give:
□ 1-3 Hours
□ 4-6 Hours
□ 6 or more hours

What kind of experience have you had that you feel might help you as a hospice volunteer? _____

_____

_____

_____

_____

Two Personal References (excluding family members). Please provide a complete address, as references are verified by mail.

Name_____ Phone ( )_____

Address_____City_____Zip_____

Name_____Phone ( )_____

Address_____City _____Zip_____

Signature: _____ **Date:** _____