

**SONATA HOSPICE  
VOLUNTEER APPLICATION**

Thank you for your interest in becoming a hospice volunteer. Please complete both sides of this application and return it to the address listed.

Name (Last, First, MI)	Are you over 18 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No	DOB (Month/Day)
Address:	Home Phone:	
City, St, Zip:	Cell/Pager:	
Employer:	Work Phone:	
Occupation:	Working Hours:	
Briefly describe the type of work you do:		
Total number of hours per week you could be available for hospice volunteering: <input type="checkbox"/> Daytime: _____ <input type="checkbox"/> Evenings _____ <input type="checkbox"/> Weekends _____ <input type="checkbox"/> Other: _____		
Level of Education: <input type="checkbox"/> High School <input type="checkbox"/> 2 Year College <input type="checkbox"/> 4 Year College <input type="checkbox"/> Post Graduate		
Foreign languages spoken:		

**RELIGIOUS AFFILIATION** (optional -- this assists us in proper placement of our volunteers. We server patients regardless of religious affiliation)

Catholic  Protestant  Jewish  None  Other: \_\_\_\_\_

**PERSONAL INFORMATION**

How did you hear about us?

Why do you wish to be involved in hospice?

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What organizations or clubs do you belong to?

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Have you had any experience with the terminally ill?  Yes  No

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Has someone close to you died within the past year?  Yes  No

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What do you like about yourself?

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	Yes	No
Do you have available transportation for your volunteer work?		
Do you have a valid California driver's license		
Do you have automobile liability insurance? (Auto insurance is required if you use your car for hospice work)		
Have you been convicted of a felony within the last 7 years? (Conviction will not necessarily disqualify you from volunteering)		

**List experiences you believe would be helpful to you in hospice volunteering, i.e., schooling, work, volunteer experience, office skills, arts and crafts, etc.**

Date	Type of Experience

**AREAS OF INTEREST:** (Please check areas of interest)

**Direct:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Patient and/or family visits | <input type="checkbox"/> Meal preparation | <input type="checkbox"/> Shopping/run errands  |
| <input type="checkbox"/> Relieve primary caregiver    | <input type="checkbox"/> Read to patient  | <input type="checkbox"/> Homemaking chores     |
| <input type="checkbox"/> Transportation               | <input type="checkbox"/> Write letters    | <input type="checkbox"/> Child care            |
|   |   | <input type="checkbox"/> Bereavement follow-up |

**Indirect:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Speakers bureau   | <input type="checkbox"/> Sewing/crafts | <input type="checkbox"/> Computer work                   |
| <input type="checkbox"/> Office assistance | <input type="checkbox"/> Videotaping   | <input type="checkbox"/> Music or entertaining           |
| <input type="checkbox"/> Mass mailings     | <input type="checkbox"/> Photography   | <input type="checkbox"/> Host/hostess for hospice events |

**PERSONAL REFERENCES:**

Name	Relationship	Phone

**IN CASE OF EMERGENCY:**

Name:	Relationship:
Home Phone:	Work Phone:
Physician:	Phy. Phone:

Applicant Signature:	Date:
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