

VOLUNTEER APPLICATION

Rev 05/2024



Thank you for your interest in becoming a High Peaks Hospice (HPH) volunteer! The following information has proven to be most helpful in making our volunteer assignments. **We require all individuals to wait one year from a loss before applying as a hospice volunteer.**

Please complete this form and return it to a High Peaks Hospice office or email to Volunteer Manager, Carol Bauer at cbauer@highpeakshospice.org

Name: _____ Month and Day of Birth: _____

Mailing Address: _____
Street City State Zip Code

Phone: _____ Best day/time to reach you: _____

Work Phone: _____ May we call you at work? Yes No
 Urgent only

E-mail address: _____

In case of emergency, please notify: _____

Relationship: _____ Phone: _____

REASON FOR VOLUNTEERING

Why are you interested in volunteering for High Peaks Hospice?

EDUCATION

School attended

Degree

Major

_____	_____	_____
_____	_____	_____
_____	_____	_____

VOLUNTEER APPLICATION (Continued)

VOLUNTEER EXPERIENCE (current or previous)

Where

Dates

Description of work

_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER COMMUNITY INVOLVEMENT

SPECIAL TRAINING, LICENSES, OR PROFESSIONAL CERTIFICATIONS

Physical Limitations

Are there any physical limitations that might affect which volunteer assignments you accept?

Yes

No

If yes, please specify:

- Allergies or sensitivities; please describe: _____
- Limit driving to daytime hours
- No heavy lifting or gripping
- Little or no climbing stairs
- Standing/sitting for long periods of time
- Other; please describe: _____

What special accommodations do you require to perform your volunteer placement job's essential duties:

- None

VOLUNTEER APPLICATION (Continued)

SKILLS AND INTERESTS

How comfortable are you with general office skills and work?

- Very comfortable Have general office skills Not comfortable with office work

How comfortable are you with technology?

- Very comfortable Okay with basic technology Prefer not to utilize technology

How comfortable are you with public speaking?

- Very comfortable Okay with small groups Prefer not to speak publicly

Do you speak any foreign languages? If so, please specify: _____

Do you hold professional skills or talents you wish to utilize? If so, please specify:

Do any of these activities describe the type of volunteer assignment that you are interested in? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Assisting patients with their hobbies | <input type="checkbox"/> Praying together |
| <input type="checkbox"/> Carpentry | <input type="checkbox"/> Pet care |
| <input type="checkbox"/> Cooking/Baking | <input type="checkbox"/> Providing respite for caregivers |
| <input type="checkbox"/> Sitting or walking outdoors | <input type="checkbox"/> Reading aloud |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Recording a patient's life story |
| <input type="checkbox"/> General companionship | <input type="checkbox"/> Running errands |
| <input type="checkbox"/> Handwriting cards or letters | <input type="checkbox"/> Sewing |
| <input type="checkbox"/> Light housework | <input type="checkbox"/> Singing or playing an instrument |
| <input type="checkbox"/> Meditation | <input type="checkbox"/> Educating others on hospice care |
| <input type="checkbox"/> Photography | <input type="checkbox"/> Other: _____ |

PERSONAL EXPERIENCE WITH DEATH OR LOSS

Has someone close to you died recently? If so, when; please explain the circumstances:

VOLUNTEER APPLICATION (Continued)

CATEGORIES OF HOSPICE VOLUNTEER SERVICE

Please check which type(s) of volunteer service you would like to provide:

- | | |
|---|---|
| <input type="checkbox"/> Office support | <input type="checkbox"/> Fundraising |
| <input type="checkbox"/> Patient care and caregiver respite | <input type="checkbox"/> Community events |
| <input type="checkbox"/> Bereavement support | |

AVAILABILITY

When are you available for volunteer work? Check days of the week you are available; if certain hours, please specify on the line:

	Specify Times		Specify Times
<input type="checkbox"/> Mondays	_____	<input type="checkbox"/> Fridays	_____
<input type="checkbox"/> Tuesdays	_____	<input type="checkbox"/> Saturdays	_____
<input type="checkbox"/> Wednesdays	_____	<input type="checkbox"/> Sundays	_____
<input type="checkbox"/> Thursdays	_____		

For seasonal resident or volunteers, please indicate months you are normally away:

CRIMINAL RECORD:

Have you ever been convicted for any violations of law, including traffic violations?

Yes No If yes, provide description of offense:

TRANSPORTATION

Do you have access to a reliable transportation? Yes No

Do you have a valid, current driver's license or state ID?* Yes No

Do you have current, valid auto insurance? Yes No N/A

How far from your home are you willing to commute? _____ minutes

We serve Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington Counties.
What areas towns or counties are you most interested in serving?

**Driver's license not required to be a volunteer*

VOLUNTEER APPLICATION (Continued)

PREFERENCES *Please complete this section only if you want to be a direct care volunteer for patients and their families.*

Please check any patient and/or family situations you would like to **avoid**. (Check all that apply)

- Smoking anywhere on the property Smoking inside (smoking outside OK)
- Children in the house; if so, specify age range: _____
- Extreme clutter or unsanitary conditions
- Alcoholism or recreational drug use
- History of mental or physical abuse
- Dogs Cats Both Other (Specify) _____
- Patients with a specific illness; if so, specify: _____
- Patients of a certain age range; please specify: _____

In which patient settings are you willing to serve? (Check all that apply)

- A patient's or caregiver's home
- Hospital
- Nursing home or assisted living facility

HOW DID YOU HEAR ABOUT OUR VOLUNTEER PROGRAM?

- Word of mouth _____
- Presentation _____
- Newspaper _____
- Poster _____
- Church _____
- Other: _____

VOLUNTEER APPLICATION (Continued)

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The New York State Department of Health requires us to complete employment verification from two or more previous employers where you either worked or volunteered, even if you are currently retired. If you have not worked or volunteered for two or more employers, please indicate as such in the employer fields and provide personal references below who we may contact.

1. Employer Name: _____ Job Title: _____
Start date: _____ End Date: _____
Location: _____ Phone: _____

2. Employer Name: _____ Job Title: _____
Start date: _____ End Date: _____
Location: _____ Phone: _____

Reference #1: _____ Reference #2: _____
Phone: _____ Phone: _____
Relationship: _____ Relationship: _____

To the best of my knowledge, all of the preceding information is true and accurate. I authorize High Peaks Hospice to request and obtain records to determine the accuracy of my responses. I understand that, if my application is accepted, before performing any hospice volunteering assignments, I will be asked to:

- Comply with all relevant Hospice policies, procedures, and regulations;
- Complete a course of training for the type of hospice volunteering I want to perform;
- Complete training in confidentiality of patient information;
- Give permission for High Peaks Hospice to perform a comprehensive background check with includes a criminal and driver's license check, as required by insurance regulations.

I also understand that to maintain active volunteer status, the minimum requirement is to complete one volunteer assignment per year.

Signature of Applicant

Date

For Internal use only:

Date of interview: _____ Interviewed By: _____

Interviewer's comments: _____
(Use Extra Paper If Necessary)

Signature of Interviewer