



Dr. Bob Kemp Hospice
Volunteer Application (Please Print)

Name: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_

Street City Postal Code

E-mail: \_\_\_\_\_

In case of emergency call: \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Employment History: (dates and description of work)

Five horizontal lines for employment history.

Volunteer Experience: (dates and description)

Three horizontal lines for volunteer experience.

Special Skills/Interests/Other languages spoken, written:

Three horizontal lines for special skills/interests.

When are you able to volunteer? (check all that apply)

Table with 8 columns (days of the week) and 3 rows (Morning, Afternoon, Evening).

Preference: \_\_\_\_\_

**What area of support are you interested in?** Please circle all that apply.

- Complimentary Therapies
- Reception
- Special Events/Fundraising
- Kitchen/Cooking/Baking
- Administrative/ General Office Work
- Lawn Maintenance/Gardening
- Bereavement Support
- Day Hospice
- Community Support

Other \_\_\_\_\_

**How did you hear about the hospice?**

\_\_\_\_\_  
\_\_\_\_\_

**Have you experienced a significant personal loss in the past two years?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following is a list of Dr. Bob Kemp Hospice “Values”. In the space provided, use a brief phrase or sentence, indicating what each word means to you.

Dignity \_\_\_\_\_

Integrity \_\_\_\_\_

Compassion \_\_\_\_\_

Open Communication \_\_\_\_\_

Person-Centered Care \_\_\_\_\_

Do you have a strong support system in your life? \_\_\_\_\_

What methods do you use to cope with stress? \_\_\_\_\_

\_\_\_\_\_

Do you have any health concerns that may affect your functioning as a volunteer?  
Please specify any chronic conditions (e.g. back injuries, allergies, cigarette smoke)

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**Please read the following carefully before signing this application form.**

I understand that the information provided in this application form is on permanent file with the Dr. Bob Kemp Hospice, will be kept confidential, and will be used only to assist in the Dr. Bob Kemp Hospice screening process and then in making the best possible placement for myself in an appropriate volunteer position.

I also understand that upon acceptance as a volunteer with the Dr. Bob Kemp Hospice, I am committing to:

- A police reference check and a vulnerable sector check as part of the screening process.
- Attending volunteer training and other educational sessions provided by the Dr. Bob Kemp Hospice.
- Abiding by the Dr. Bob Kemp Hospice Policies and Procedures.
- A commitment of 15 hours per month for a minimum of one year.
- The possibility that I may be assigned to the client program (home visiting, day or residential) most in need of support at any given time.

I hereby certify that the information in this application form is true and complete.

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_