Dr. Bob Kemp Hospice
Volunteer Application (Please Print)

Please note: Before applying, a minimum 12 months waiting period is required for anyone who has experience the death of a loved one. If you are receiving bereavement services through the Dr. Bob Kemp Hospice and the services extend past the minimum 12 month waiting period an additional 3 months waiting period is required after the last day of service before applying.

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)

_____

_____

_____

Volunteer Experience: (dates and description)

_____

_____

_____

Special Skills/Interests/Other languages spoken, written:

_____

_____

_____

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

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
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
Adult Bereavement Support (1:1 peer support, group facilitation)
Children's Bereavement
Adult Day Hospice/Pediatric Wellness
Volunteer Visiting

Other _____

How did you hear about the hospice?

_____

_____

Have you experienced a significant personal loss in the past year? Please share details of this loss.

_____

_____

_____

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)

_____

_____

_____

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:

- Obtaining a **Vulnerable Sector Police 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** _____

Please submit your completed application to:
Karen Nowicki, Volunteer Administrative Assistant
Dr. Bob Kemp Hospice
277 Stone Church Road East
Hamilton, ON L9B 1B1
Email to: knowicki@kemphospice.org