



Ogeechee Area Hospice, Inc.  
HOSPICE VOLUNTEER APPLICATION

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL/MOBILE \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION/JOB TITLE: \_\_\_\_\_

WORK HOURS: \_\_\_\_\_ CAN YOU RECEIVE CALLS AT WORK?  YES  NO

HIGHEST EDUCATION COMPLETED: \_\_\_\_\_ MAJOR STUDIED: \_\_\_\_\_

FOREIGN LANGUAGE (if any): \_\_\_\_\_

ARE YOU A LICENSED VOLUNTEER PROFESSIONAL? Please check all that apply.

Pastor  RN  Counselor  Cosmetologist

FORMER EMPLOYEES: (List the last two employers starting with the most recent one first)

Employer Name	Address & Phone	Position	Dates of Employment

REFERENCES: Name 3 people not related to you, whom you have known at least 2 years.

Name	Address	Relationship	Phone Number

HOW DID YOU HEAR ABOUT OGEECHEE AREA HOSPICE? \_\_\_\_\_

WHY DO YOU WANT TO VOLUNTEER HERE? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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HOW DID YOU BECOME INTERESTED IN HOSPICE? \_\_\_\_\_

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**PLEASE CHECK WHICH AREA(S) ARE OF INTEREST TO YOU AS A HOSPICE VOLUNTEER**  
(You may wish to complete this during the interview process):

**1. Patient/Family Care**

- |                                       |                                           |                                   |
|---------------------------------------|-------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Home Care    | <input type="checkbox"/> Assisted Living  | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Inpatient Center | <input type="checkbox"/> Other    |

**2. Non-Patient Services**

- |                                          |                                           |                                    |
|------------------------------------------|-------------------------------------------|------------------------------------|
| <input type="checkbox"/> Office/Clerical | <input type="checkbox"/> Mailings         | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Welcome Desk    | <input type="checkbox"/> Speaker's Bureau | <input type="checkbox"/> Other     |

**3. Bereavement Services**

- |                                   |                                          |                                |
|-----------------------------------|------------------------------------------|--------------------------------|
| <input type="checkbox"/> Caller   | <input type="checkbox"/> Office/Clerical | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mailings | <input type="checkbox"/> Children's Camp |                                |

**IN WHICH COUNTY(IES) WILL YOU BE WILLING TO SEE PATIENTS?**

- |                                             |                                           |                                  |                                |                                  |                                  |                                   |
|---------------------------------------------|-------------------------------------------|----------------------------------|--------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Bulloch            | <input type="checkbox"/> Bryan            | <input type="checkbox"/> Candler | <input type="checkbox"/> Evans | <input type="checkbox"/> Jenkins | <input type="checkbox"/> Screven | <input type="checkbox"/> Tattnall |
| <input type="checkbox"/> Parts of Effingham | <input type="checkbox"/> Parts of Emanuel |                                  |                                |                                  |                                  |                                   |

**HAS A CLOSE FAMILY MEMBER/SIGNIFICANT OTHER DIED IN THE LAST YEAR?** If yes, please explain. \_\_\_\_\_

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**HOW MANY HOURS (approximate) DO YOU HAVE AVAILABLE EACH WEEK?** \_\_\_\_\_

**WHEN WOULD YOU BE AVAILABLE TO VOLUNTEER?**  Daytime  Weekends  
 Evenings/After Work  Flexible/Most Any Time of Day

**VOLUNTEER EXPERIENCE:** List the dates, organizations, and duties of any volunteer work you have done in the past or are currently serving. \_\_\_\_\_

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**LIST ANY TALENTS/SKILLS YOU POSSESS THAT YOU WOULD BE WILLING TO SHARE WITH OGEECHEE AREA HOSPICE.** \_\_\_\_\_

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**HAVE YOU EVER BEEN WITH SOMEONE AT THE TIME OF THEIR DEATH?**

YES  NO If yes, please briefly explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER PROVIDED CARE TO ANYONE WHO WAS DYING?**  YES  NO

If yes, please briefly explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAVE YOU EVER BEEN DISMISSED OR FORCED TO RESIGN FROM ANY EMPLOYMENT OR VOLUNTEER POSITION?**  YES  NO If yes, please explain. \_\_\_\_\_

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

**HAVE YOU EVER BEEN CONVICTED OF A FELONY?**  YES  NO If yes, please explain.

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

**DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT PRELUDE YOU FROM SAFELY PERFORMING THE WORK FOR WHICH YOU ARE BEING CONSIDERED WITHOUT THE RISK OR INJURY TO YOURSELF OR OTHERS?**  YES  NO If yes, please explain.

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

I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that, if employed (volunteers are considered non-compensated employees of Ogeechee Area Hospice), falsified statements on this application shall be grounds for dismissal.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I understand and agree that, if hired for volunteer service, my employment is for no definite period of time and may be terminated at any point by either Ogeechee Area Hospice or volunteer.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE MAIL THIS APPLICATION TO: Ogeechee Area Hospice, Inc.  
c/o Volunteer Coordinator  
P. O. Box 531  
Statesboro, GA 30459