



Box 624, 17 McKenzie Street, Madoc, Ontario, K0K2K0  
 Phone: 613-473-1880 Fax: 613-473-4070

## VOLUNTEER/BOARD MEMBER APPLICATION FORM

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

**What areas of volunteering interest you?**

<input type="checkbox"/> Board Member	<input type="checkbox"/> In-Patient Care (Residential Hospice)	<input type="checkbox"/> Caring for Children	<input type="checkbox"/> Event Coordination
<input type="checkbox"/> Committee Member	<input type="checkbox"/> Bereavement Support	<input type="checkbox"/> Driving	<input type="checkbox"/> Cleaning/Cooking/Baking
<input type="checkbox"/> In-Patient Care (Community)	<input type="checkbox"/> Complementary Therapy	<input type="checkbox"/> Fundraising Events	<input type="checkbox"/> Gardening

**VOLUNTEER INFORMATION**

Name:		Email:	
Street address:			PO Box:
City:	Postal Code:		Phone:
Telephone: (Home)		(Work)	(Cell)
Emergency Contact:			Telephone:

**Please list any previous related work experience, volunteer experience, or community work**


**Please list any special skills, Education, Training, Hobbies and Interests you have**


**Please select the age category that best describes you**

Teen	Student
Adult	Retired

**Do you speak, write or read in any languages other than English?**       yes       no

Speak:	Write <input type="checkbox"/>	Read <input type="checkbox"/>
Speak:	Write <input type="checkbox"/>	Read <input type="checkbox"/>
Speak:	Write <input type="checkbox"/>	Read <input type="checkbox"/>

**Which Ethnic Cultures are you familiar with?**

**What qualities or special abilities do you have that are related to hospice services and/or programs?**

**Please select the appropriate responses:**

**I would feel comfortable volunteering with clients who are or are diagnosed with:**

Cancer	A.L.S.	Heart Disease	Teen Aged
Kidney Disease	Hepatitis	Disabled (mental/physical)	Elderly
Lung Disease	Aids/HIV	Young Children	Bereaved

**I would be willing to visit:**

Male clients only	Female clients only	Male or Female clients	Children
Clients who smoke	Clients who do not smoke	Clients who own pets	Clients without pets

**Have you had any personal bereavement experience?**

**What are your expectations of your assignment?**

**POLICE CHECK**

The Heart of Hastings Hospice by policy and regulations requires a Police Check to be done on all new volunteers and board members. If you have already had one done within the last six months, please provide a copy. You will be given a form to fill out to complete this process.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_