BLESSING
Hospice & Palliative Care

Application for Volunteer Service Date: ______________

Name: ____ DOB: ______________

Address: ____

____

Phone: (h) _____________________ (c) __________________ _

Email: ____

Mark all Counties willing to serve:

Adams____ Brown_____ Hancock_____ Pike_____ Greene_____ Jersey______ Calhoun______

Type of Service(s) Desired:

Administrative: Various Office Duties and /or Phone Calls______ Post Admission Calls_______

Reception Desk_____ Scanning Documents______ Public Speaker _______Trainer_______

Patient Care: Socialization____ Respite______ various types of Errands_____ Other_______

Bereavement: Social Visit_________ Phone Calls________

B.E.S.T. (Bedside Emotional Support Team) ____

List any Special talents that you are willing to share. (Ex.-Music talent-Hair Stylist-Juggler) _______

____

References: (Non-relative)

1. Name: ____
   Address: ____
   City/State/Zip: _________________________________ Telephone: ____________________

2. Name: ____
   Address: ____
   City/State/Zip: __________________________________ Telephone: __________________

DECLARATION AND AUTHORIZATION

I, _________________________________ certify that all information that I have provided to you is true, accurate and complete. I authorize you to contact my named references to seek information from them that may be relevant to my application for volunteer service. I release them and Blessing Health System from any/all liability for any damages whatsoever that may occur as a result of this exchange of information. I understand that all work with Blessing Hospice and Palliative Care and its patients are of a confidential nature and that all of my volunteer services are performed without compensation. I have read and understand the ICARE standards.

Signed (Volunteer): ________________________________ **Date:** ________________________

Signed (Vol. Coordinator): ____________________________ **Date:** _________________________

12/2012 LC