

**VOLUNTEER APPLICATION
FOR
HOSPICE OF GLADWIN AREA, INC**

(Please print or type and return.)

SECTION I: PERSONAL DATA (Starred items * are optional.)

NAME _____ BIRTH DATE ___/___/___

STREET ADDRESS _____ APT # OR BOX _____

CITY _____ ZIP _____ SEX: * M F

PHONE NUMBER (S) HOME _____ WORK _____
(At work, what are your normal/usual days and/or hours? _____)

CURRENT EMPLOYER _____

RELIGIOUS PREFERENCE * _____

DRIVER'S LICENSE NUMBER _____

Have you ever been convicted of charges stemming from:

_____ Use/possession of an illegal drug?

_____ Theft?

_____ Euthanasia (mercy killing)?

EMERGENCY CONTACT: NAME _____

RELATIONSHIP TO YOU: _____ PHONE # (____) _____

FOREIGN LANGUAGE: _____ UNDERSTAND ___ READ ___ SPEAK ___

SECTION II: EDUCATIONAL DATE (Indicate highest level attained)

HIGH SCHOOL 1 ___ 2 ___ 3 ___ 4 ___ COLLEGE 1 ___ 2 ___ 3 ___ 4 ___

DEGREE TYPE _____ GRADUATE STUDIES _____ DEGREE _____

PROFESSIONAL TRAINING _____

SEMINARS/ TRAINING IN DEATH EDUCATION _____

OTHER TRAINING _____

Continue -----

SECTION III: EXPERIENCE WITH LIFE THREATENING ILLNESSES

Have you any chronic health problems or disabilities? Yes _____ No _____
If yes, explain _____

Have you ever been seriously ill ? _____ If yes, what was the cause of the illness? _____

Has any family member/close friend had a serious illness? _____ Did it result in death? _____

If yes, who and how recently? _____

Please comment on that experience: _____

SECTION IV: REFERENCES (Please list three personal or professional references - non family.)

1. Name _____ Address _____

City and ZIP _____ Phone _____

2. Name _____ Address _____

City and ZIP _____ Phone _____

3. Name _____ Address _____

City and ZIP _____ Phone _____

* * * * *

SECTION V: RATIONALE

In order to better acquaint us with yourself, please indicate your reasons for wanting be serve as a Hospice volunteer.

Are you willing and able to participate in the Hospice Training Program (30 hours) Yes _____ No _____

I, THE UNDERSIGNED, ATTEST THAT THE INFORMATION ON THIS APPLICATION IS TRUE.
I grant my consent for Hospice of Gladwin Area to contact those persons listed as personal references.

Applicant's signature _____ Date _____

Please return this application as soon as possible to: HOSPICE OF GLADWIN AREA, INC
P O BOX 557
GLADWIN MI 48624

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