

7020 Moon Road Phone: (706) 569-7992

Columbus, GA 31909 FAX: (706) 569-8560

Dear Potential Volunteer:

Thank you for your interest in Columbus Hospice, Inc. **The Columbus Hospice Volunteer Program is an excellent one, but is not a commitment to be taken lightly**. Our volunteers are required by governing regulations to complete an initial on-site training, plus 3 additional workshops per year as well as CPR certification training for volunteers who have contact with patients. At training each volunteer will submit to tuberculosis testing, a criminal background check with finger printing, and will be given a voucher to obtain a drug screen. All testing must be completed prior to becoming active with the volunteer department. Again, we ask a lot of our volunteers, but the rewards are definitely worth your time! All document processing and costs associated with required medical testing are covered by Columbus Hospice. If you cannot take a tuberculosis test/PPD we require a chest x-ray. The cost for the chest x-ray is not covered by Columbus Hospice. We will ask you to complete a medical questionnaire prior to becoming an active volunteer.

**All volunteers will be required to provide proof of being fully vaccinated against COVID-19 prior to volunteering and will be required to provide proof of or obtain the influenza vaccine offered by Columbus Hospice during influenza season annually**

There is much to be gained from being a hospice volunteer. To volunteer is to choose to act in recognition of a need, with attitude of social responsibility, and without concern for monetary profit. As a volunteer you will learn to listen effectively, which may be the most important service you provide. Volunteers can listen to concerns, run errands, create crafts, bake, assist with fundraising, perform handyman repairs, do yard work, music and pet therapies, and so much more!!

The application process includes federal and state **mandated** forms to ensure patient and volunteer safety. The application must be completed and delivered to Volunteer Office prior to being scheduled for training. Once you have completed all paperwork you will be contacted about the next new volunteer training.

I hope you feel you can meet our volunteer requirements and would like to become part of our team. If you have any questions, please feel free to call me at (706)341-4642. Thanks again for your interest.

Sincerely,

Volunteer Services

**VOLUNTEER APPLICATION**

Name of Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best time to contact: a.m. p.m. Preferred contacts: mail email cell phone home phone work phone

Educational Background: high school College

Special Training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# AREAS OF INTEREST

**Patient/Family Companion**:

In Home Nursing Home Hospice House Bereavement Hair Stylist Pet Program Vet Program

**Non-Patient Services**:

Clerical Fundraising Yardwork/Handyman Special Events/Baking Receptionist

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Do you know a language other than English? Yes No

Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speak Read Write

Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Speak Read Write

Other Special Services: (manicurist, hairdresser, massage therapy, pet therapy, music therapy, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did you hear about our Hospice Volunteer Program? radio TV church Newspaper article

hospice letter relative friend other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why do you want to be a Hospice Volunteer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What qualities (skills, talents, knowledge, experience, etc.) do you feel you can incorporate into your Hospice Volunteer work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**(Continued on Reverse**)

**VOLUNTEER APPLICATION – continued**

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**Death and Dying**

Have you ever been with someone at the time of his or her death? Yes No If yes, please describe briefly

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

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Have you had someone in your immediate family die within the last year? Yes No If yes, what was the

relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever provided care to anyone who was dying? Yes No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When thinking of your own death, what words best describe death to you?

I do not think about my own death Sorrowful Natural Frightening Painful Lonely Joyful

Heavy Peaceful Dark Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I interpret “volunteer” to mean that I have agreed to work without compensation in money. Having been accepted as a volunteer worker, I expect to do my work according to standards set forth in the Volunteer Policies and Procedures.**

**Declaration**

**I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that by submitting this application I authorize inquiries to be made concerning my employment, character and public records for the purpose of determining my suitability as a volunteer. I agree to respect the confidentiality of any client information I acquire in the course of my volunteer activities with Hospice**.

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

**Signature of Applicant Date**

**COLUMBUS HOSPICE, INC.**

**VOLUNTEER EMERGENCY PROFILE**

This information is required for notification in the event of an emergency. Please update as changes occur. All information will be kept confidential.

**VOLUNTEER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Information**: (Next of kin, family, and close relatives or friends)

**Contact 1st** **Contact 2nd**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Physician**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Hospital**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2d Hospital Choice**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Information which might be helpful in an emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you drive please provide verification of current car insurance coverage for your vehicle. This is required regardless of the activities that you will be performing for

Columbus Hospice. Thank You.