

Mail application:
P.O. Box 392
Nichols, SC 29581

Fax application:
843.526.1389

Shepherd Care Hospice LLC

VOLUNTEER APPLICATION

Thank you for your interest in volunteering for Shepherd Care Hospice. PLEASE PRINT your responses to the items on this form and return it to the DIRECTOR OF VOLUNTEERS at the above address. This information is confidential and will be for Shepherd Care Hospice use only.

Mr./Mrs./Ms. Last Name: _____ First Name: _____

Street Address: _____ City: _____ SC Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Place of Employment: _____ Full Time ___ Part Time ___

Birth Date: Month ___ Day ___ Year ___ Social Security: ___/___/___

Emergency Contact: _____ Relationship: _____ Phone: _____

Education: Please check the highest level completed.

- High School Some College College Degree Post Graduate
 Technical Other _____ Presently in school

Work Experience: Please describe your current or previous profession and work experience.

Availability to volunteer: Year round Seasonal Months available: _____

Days of the week you are available: (circle all that apply) **Mon Tue Wed Thu Fri Sat Sun**

Time of day available: ___ AM ___ PM ___ EVE Number of hours per day? _____

Projected start date as a Hospice Volunteer: _____

-
- Yes No Do you have transportation?
 Yes No Do you have valid auto insurance?
 Yes No Do you know a foreign language? List: _____
 Yes No Do you have sign language skills?
 Yes No Do you have computer skills? List: _____

List any other experience, skills or information that will assist us in matching you to a described volunteer assignment: _____

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- Yes No Have you experienced the loss of a loved one within the last 12 months?
If yes, what was the relationship? _____
- Yes No Did you have a Friend/Relative who is/was a Hospice patient?
- Yes No Have you ever been a caregiver for someone who has died?
When? _____ Relationship? _____
- Yes No Have you performed volunteer work before?
If yes, where? _____
- Yes No Are you active in other organizations?
If yes, which organizations? _____

How did you learn about volunteering at Shepherd Care Hospice?

- Friend Family member Brochure Other: _____

SPECIAL INTERESTS:

Hobbies: _____

Special Skills: _____

Special Interests: _____

Military Service: (please specify) _____

AREAS OF INTEREST: (Please mark all that apply)

- CLERICAL/ADMINISTRATIVE:** Volunteers assist Hospice staff by carrying out a variety of office tasks which may include mailings, assembling packets of literature and documents, faxing, data entry, telephoning and filing. Volunteers' duties are based on their skills.
- COMMUNITY RELATIONS:** Volunteers assist in planning, organizing, and staffing special events, health fairs/expos, public speaking, and assisting with life enrichment functions.
- PATIENT CARE:** After successfully completing an intensive training program, Patient Care Volunteers work directly with hospice patients and their families helping them sustain the highest quality of life while managing the challenges of life threatening illnesses. Volunteers visit with patients to provide respite for caregivers, provide rides to appointments, shopping, or run errands. Patient Care Volunteers may elect to work in patients' homes, assisted living facilities, or nursing homes.

If you are interested in direct patient care work, please tell us why you selected this area of volunteer work: _____

Please provide 3 personal references (not related) include phone and complete mailing address.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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RESPONSIBILITIES / RECORD KEEPING

Volunteers are at the heart of hospice. Without you, the Volunteer, Shepherd Care Hospice could not operate. A Federal mandate states that Volunteers must provide a minimum of 5% of total patient care hours. Therefore, each Volunteer is responsible for recording their volunteer time which includes travel time to and from your hospice assignments. You will be instructed on where and how to record your hours. If you cannot fulfill your assignment on a particular day or during vacations, you must notify the Volunteer Director. Please, if possible, give us time to find a replacement in the event of your absence. There is room for all Volunteers regardless of the amount of time you can contribute. We work with you to structure your time commitment to meet your needs.

STATEMENT OF CONFIDENTIALITY

I understand that many types of information to which I have access during the course of my volunteering at Shepherd Care Hospice, are strictly confidential and may not be released or discussed. Additionally, I understand that patient/family information may only be given to employees, who have a legitimate need to know based on their involvement with the treatment of that particular patient/family.

Confidential information which I may have access to includes without limitation:

- Internal Agency information such as:
Contracts, Financial Reports, Salary, Personnel lists
- Patient Identifiable Medical/Clinical information
- Patient/Family Financial and Billing information
- Computer passwords

I understand that I must safeguard against accidental observation/release of these kinds of information in any format (hard copy, computer screens or disks, verbal discussions, etc.) to non-authorized personnel.

I further understand that improper release of these kinds of information will be grounds for disciplinary action up to and including termination of my volunteering.

Print Name

Signature

Date

Please provide a photocopy of your drivers' license and your current auto insurance coverage.

SHEPHERD CARE HOSPICE MISSION STATEMENT

The mission of service is to increase the availability and access to quality hospice and palliative care for patients and families within the communities in which we serve. Shepherd Care Hospice understands that human caring is the most awesome God given gift. The Company intends to eliminate all barriers of access and communication while providing professional, sensitive and quality end of life care.