



VOLUNTEER APPLICATION

NAME _____ DATE _____

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE (H) _____ (W) _____ (MOBILE) _____

EMAIL _____

PLEASE LIST THE SPECIFIC TIMES YOU WOULD HAVE AVAILABLE TO VOLUNTEER WITH HOSPICE CALGARY: (I.E. HALF-DAYS, HOURS, EVENINGS, WEEKENDS, ETC.)

SCHOOLS/EDUCATION AND/OR OTHER RELEVANT COURSE WORK:

LANGUAGES SPOKEN: _____ WRITTEN: _____

IF CURRENTLY EMPLOYED, PLEASE PROVIDE:

NAME OF EMPLOYER _____

POSITION HELD _____

DATE EMPLOYED _____ HOURS EMPLOYED _____

LIST PREVIOUS EMPLOYERS:

PREVIOUS VOLUNTEER EXPERIENCE: (PLEASE DESCRIBE ANY VOLUNTEER EXPERIENCES. INCLUDE SUCH INFORMATION AS NAME OF ORGANIZATION, LENGTH OF STAY, NATURE OF YOUR INVOLVEMENT, AND REASON FOR LEAVING).

THE VOLUNTEER POSITION MAY INVOLVE TRAVEL WITHIN CALGARY CITY LIMITS (EG. TO PATIENT'S HOME.) THE VOLUNTEER IS RESPONSIBLE FOR PROVIDING HIS/HER OWN TRANSPORTATION. WILL THIS BE ACCEPTABLE TO YOU?

YES _____ NO _____

THE FOLLOWING QUESTIONS RELATE SPECIFICALLY TO HOSPICE-TYPE WORK. THE PERSONAL INVOLVEMENT REQUIRED OF A VOLUNTEER MAKES IT NECESSARY FOR PROBING QUESTIONS TO BE ASKED.

1. **WHY ARE YOU INTERESTED IN BEING A VOLUNTEER WITH HOSPICE CALGARY?**

2. **HAVE YOU HAD PREVIOUS EXPERIENCES WITH DEATH? (IF YES, PLEASE EXPLAIN THE CIRCUMSTANCES, INCLUDING DATES).**

3. **WHAT SATISFACTION/REWARDS DO YOU FEEL YOU WILL RECEIVE FROM THIS VOLUNTEER EXPERIENCE?**

4. **WHAT DO YOU FEEL YOU CAN CONTRIBUTE TO THE WORK OF HOSPICE CALGARY? (PERSONAL STRENGTHS, EXPERIENCES, ETC.)**

5. **DO YOU HAVE ANY PHYSICAL LIMITATIONS THAT WE SHOULD BE AWARE OF IN ASSIGNING YOU AS A VOLUNTEER? PLEASE EXPLAIN.**

6. **DESCRIBE BRIEFLY HOW YOU INTERACT WITH AND RELATE TO THOSE WITH CULTURAL AND RELIGIOUS BACKGROUNDS, AND/OR VALUE SYSTEMS THAT DIFFER FROM YOUR OWN.**

7. **PLEASE LIST ANY HOBBIES, ACTIVITIES OR INTERESTS:**

8. **WILL YOU COMMIT TO ATTENDING THE FULL VOLUNTEER TRAINING PROGRAM? (PLEASE NOTE, COMPLETION OF THE TRAINING PROGRAM DOES NOT GUARANTEE CONTINUED VOLUNTEER INVOLVEMENT IN A PATIENT-RELATED CAPACITY). YES _____ NO _____**
9. **DO YOU HAVE STANDARD FIRST AID: YES _____ NO _____**

PLEASE PROVIDE THE NAMES OF THREE PEOPLE (INCLUDING ADDRESSES AND POSTAL CODES) HOSPICE CALGARY SOCIETY CAN CONTACT AS A REFERENCE. (TWO PERSONAL REFERENCES AND ONE FROM EITHER A PHYSICIAN, CLERGY, EMPLOYER, VOLUNTEER DIRECTOR OR OTHER PROFESSIONAL).

1. NAME _____ OCCUPATION _____
ADDRESS _____
POSTAL CODE _____ PHONE _____ RELATIONSHIP _____
EMAIL: _____
2. NAME _____ OCCUPATION _____
ADDRESS _____
POSTAL CODE _____ PHONE _____ RELATIONSHIP _____
EMAIL: _____
3. NAME _____ OCCUPATION _____
ADDRESS _____
POSTAL CODE _____ PHONE _____ RELATIONSHIP _____
EMAIL: _____

I AGREE TO GIVE HOSPICE CALGARY SOCIETY PERMISSION -

- TO CONDUCT A REFERENCE CHECK WITH ANY EMPLOYER, AGENCY OR PERSONAL CONTACT LISTED ABOVE.
- TO CONDUCT A SECURITY CLEARANCE CHECK WITH THE CALGARY POLICE SERVICE UPON COMPLETION OF THE APPLICABLE FORM.
- TO CONDUCT AN ALBERTA CHILDREN'S SERVICES INTERVENTION RECORD CHECK UPON COMPLETION OF THE APPLICABLE FORM.
- TO SIGN A CONFIDENTIALITY AGREEMENT IF ACCEPTED AS A VOLUNTEER.

SIGNED _____ DATE _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS APPLICATION.

Revised November 2008