



<i>Office Use Only</i>
Date application rec'd _____
<input type="checkbox"/> Rec'd organizational vol app.
<input type="checkbox"/> OIG completed

Patient Care Volunteer Application

Applicants must be 18 years or older and have a valid U.S. Social Security Number and Driver's License/ State ID.

We ask for a **1-year minimum commitment and 4-hour per week availability** for our general patient care volunteers.

(6 month, 2-hour per month minimum commitment for volunteers providing licensed/ certified specialty services only)

Title (please circle one): Mr. Mrs. Ms. Miss. Dr.							
Name (last, first):			Preferred First Name:				
Address:			City:	Zip:			
Phone 1:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work	Phone 2:	<input type="checkbox"/> Home	<input type="checkbox"/> Cell	<input type="checkbox"/> Work
E-mail address:							
Occupation (if retired, please list previous occupation):							
Driver's License #:			State:	Vehicle Ins. Carrier:			
In Emergency Notify:			Relationship:	Phone:			
Why have you chosen to volunteer with San Diego Hospice and The Institute for Palliative Medicine (SDHIPM)?							
What personal characteristics will enable you to work with people who are facing a terminal illness?							
Please describe any work or other experiences which you feel has prepared you to be a Patient Care Volunteer:							
The last death I was impacted by was _____ year(s) ago and the relationship was _____.							
Fluent languages (other than English):							
Have you ever been convicted of a felony, or been notified of any exclusion actions? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Specialty Skills: Indicate specialty skills you are willing to provide as a volunteer. Current certification or professional license required. (Please attach to application.)							
<input type="checkbox"/> Hairstyling <input type="checkbox"/> Healing Touch <input type="checkbox"/> Massage <input type="checkbox"/> Notary <input type="checkbox"/> Pet Therapy <input type="checkbox"/> Reiki							
License Type: _____ License #: _____ Expiration Date: _____							
References: I understand that I will be required to provide two reference forms to individuals who know me on a personal or professional basis. By checking this box, I am authorizing SDHIPM to contact my references regarding my appropriateness as a patient care volunteer: <input type="checkbox"/>							
Referral Source: How did you hear about volunteering with San Diego Hospice and The Institute for Palliative Medicine?							
<input type="checkbox"/> Family/Friend		<input type="checkbox"/> TV/Radio/Newspaper (specify) _____					
<input type="checkbox"/> SDHIPM Staff / Volunteer (name) _____		<input type="checkbox"/> Internet (specify website) _____					
<input type="checkbox"/> Brochure / Flyer (specify location) _____		<input type="checkbox"/> Other (specify) _____					
Signature				Date			

Please return completed application to:
San Diego Hospice and The Institute for Palliative Medicine - Volunteer Resources, 4311 Third Avenue San Diego, CA 92103
Phone: 619- 278-6451 • Toll free: 866-688-1600 • Fax: 619-688-0017 • Email: volunteer@sdhospice.org • Web: www.sdhospice.org