

# Richmond Hospice Association

## Hospice Training Application Form

\_\_\_\_\_ Date of application

### PERSONAL INFORMATION

Last Name: \_\_\_\_\_ Usual First Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cellular: \_\_\_\_\_

Email: \_\_\_\_\_

Religious affiliation (if any): \_\_\_\_\_

Languages spoken/written: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Present occupation: \_\_\_\_\_

Educational background: \_\_\_\_\_

Please list any other special skills or training or hospice courses taken: \_\_\_\_\_

Do you have a valid BC Driver's Licence? Yes  No

Is a car available to you? Yes  No

How did you hear about Richmond Hospice Association?

- Newspaper  Brochure / poster  
 Friend  Other: \_\_\_\_\_

In what areas do you wish to be involved? Please check all that apply.

- Home visiting  Office work  
 Special events  Other: \_\_\_\_\_  
 Hospital visiting

**AVAILABILITY**

Please check the days and times that you are realistically able to volunteer:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Mornings							
Afternoons							
Evenings							

Are you willing to give a minimum time commitment of at least one year?

Yes  No

If NO, please elaborate: \_\_\_\_\_

Please describe any previous/current volunteer experience: \_\_\_\_\_

\_\_\_\_\_

What do you feel are the strengths that you will bring to your volunteer work? \_\_\_\_\_

\_\_\_\_\_

What do you feel are the limitations that you will bring to your volunteer work? \_\_\_\_\_

\_\_\_\_\_

Why do you want to become a Hospice volunteer? What experiences have you had that make you feel you are suited for this work?

\_\_\_\_\_

\_\_\_\_\_

Briefly describe your personal experience with loss/death/bereavement.

\_\_\_\_\_

\_\_\_\_\_

Describe your personal support system.

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Do you have any concerns or are there any frustrations you think you might experience as a volunteer?

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Are you willing to complete a criminal records check?      Yes       No

If NO, please elaborate: \_\_\_\_\_

**REFERENCES**

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

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

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

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

*I understand that there is a 3-month probationary period, at which time any concerns that I, or the Program Coordinator, may have will be addressed.*

*I will respect the confidentiality of the Richmond Hospice Association, and of their clients and families.*

**Signature of applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Thank you for taking the time to fill out this form. Once your application has been received and reviewed, you will be asked to attend a screening interview. If you still wish to be involved with Hospice after training is completed, you will be asked to sign the Volunteer Commitment and Confidentiality form.**

**For office use only**

Date received:	Date called:	Interview date: