



## Volunteer Application

*Volunteers are an integral part of the team of professionals at Home & Hospice Care of Rhode Island.  
We appreciate your interest in supporting our mission. Please send your completed application to:  
Home & Hospice Care of Rhode Island, Volunteer Department, 1085 North Main Street, Providence, RI 02904  
Phone 401-415-4200 fax 401-415-4345*

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

**I may be contacted at:**

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Person to be notified in case of emergency: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Can you receive calls at work? Yes  No  Emergency Only

Work Schedule: \_\_\_\_\_

I am available to volunteer: Weekdays  Evenings  Weekends

**Education/ Special Training:**

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

**Work Experience:**

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

**Two Personal References (excluding family members). Please provide a complete address and phone number.**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Area(s) of interest: (Check all that apply)

**Direct Service:** Patient Care - Companionship, Respite for caregiver, Assist with project, Vigils, etc.

- In Homes
- In Long Term Care Facility
- Transportation/Errands
- Special projects
- Complementary Therapy
  - Reiki       Massage
  - Music       Pet
  - Art       Reflexology
  - Hairdresser    Manicurist

**Indirect Service:** Administrative, Activity, Event or Foundation Volunteer

- Data entry – computer work
- Answer telephone
- Assemble packets
- Speaker’s Bureau
- Filing/copying
- Office mailings
- Fundraising activities
- Special projects

Do you know a language other than English?    Yes                       No

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

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

Do you have access to transportation?    Yes                       No

How did you hear about Home & Hospice Care of Rhode Island?

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Why do you want to be a hospice volunteer?

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What qualities (skills, knowledge, experiences) do you feel you can incorporate into your hospice volunteer work?

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Do you have any allergies? (pets, smoke, other) \_\_\_\_\_

Do you volunteer with other organizations? Please list: \_\_\_\_\_

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What are your thoughts and feelings about death? \_\_\_\_\_

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Have you ever been with someone at their death? Yes     No  If yes, please describe briefly

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Have you ever provided care to someone who was approaching end of life? Yes     No  If yes, please describe briefly

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\*\*Have you experienced a significant loss in the past year? Yes     No  Relationship: \_\_\_\_\_

*\* Home & Hospice Care of Rhode Island follows the National Hospice and Palliative Care Organizations standards of practice, which recommends that anyone interested in doing direct patient volunteering must wait one year after the loss of a loved one before entering our training program.*

**Code Of Ethics For Volunteers**

As a volunteer, I realize that I am subject to Home & Hospice Care of Rhode Island’s (HHCRI) Code of Ethics which binds the professional in the field in which I work.

**I understand that any information that is disclosed to me while assisting Home & Hospice Care of Rhode Island is confidential.**

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

**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 patient information that I acquire in the course of my volunteer activities with Home & Hospice Care of Rhode Island.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**