Hospice Care
Reaching Higher To Serve You

Hospice Volunteer Application

Thank you for your interest in the Agape Hospice Care Volunteer Program. We appreciate the time and though you will put into this application

Agape Hospice Care does not discriminate against any person on the basis of race, color, religion, material status, national origin, physical or mental disability gender, sexual orientation, or age in admission, treatment or participation in its programs, services and activities including employment.

All information supplied herein is confidential:

Name:		Date:	
Address		Are you 18 or older? ☐ Yes ☐ No	
City	State:	Zip Code	
Cell Phone:	E-Mail:		

Emergency Contact Information

Name:	Relationship:	Phone Number

Volunteer Time & Area

What cities are most convenient for you to volunteer?

____

____

____

____

____

What days are you able to volunteer?

Monday ☐ Wednesday ☐ Friday ☐ Sunday ☐

Tuesday ☐ Thursday ☐ Saturday ☐

What times are you able to volunteer?

Mon. ____________________ Fri. ____________________

Tues. ____________________ Sat. ____________________

Wed. ____________________ Sun. ____________________

Thurs. ____________________

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Areas of Interest

- ☐ Direct Care
- ☐ Indirect Care
- ☐ Administrative Support
- ☐ Community Outreach
- ☐ Complementary Services
- ☐ Veterans

List any skills, talents or knowledge and/or experiences you feel you can incorporate into your hospice volunteer work:

____

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____

Additional Information

Besides English, do you communicate in any other languages? ____________________

What is your motivation for volunteering with Agape Hospice Care and what do you expect from this experience?

____

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What is your experience with life threatening and end-stage illness? What effects has this had on you?

____

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____

References

Please List two references:

Name:	Years Known:
In what capacity?	Phone:

Name:	Years Known:
In what capacity?	Phone:

Code of Ethics for Volunteers

As a volunteer, I realize that I am subject to a code of ethics similar to that which binds the professional field in which I work. I, like them assume certain responsibilities and expect to account for what I do in terms of what is expected of me.

I understand that information disclosed to me while assisting the Hospice is confidential

I interpret "volunteer" to mean that I have agreed to work without compensation in money but upon being accepted as a volunteer worker, I expect to do my work as set forth by the Agape Hospice Interdisciplinary Team Plan of Care

Background Check Authorization and Release Form

THIS FORM CANNOT BE PROCESSED IF INCOMPLETE, ILLEGIABLE, OR INACCURATE

I,____________________________________, having applied for the position of
(Please Print Full Legal Name)

volunteer, do hereby authorize **AGAPE HOSPICE CARE INC.,** to obtain any information regarding my background, traffic information, including history of violations and status of Driver's License, education history and employment history including evaluations.

Said information is to be released to **AGAPE HOSPICE CARE INC.**

I further release and hold harmless any employee of AGAPE HOSPICE CARE INC., and any business or individual who supplied said information, from in liability resulting in dissemination of said information.

Driver's License # or ID# __________________________ State______________________

SSN#________________________________ Place of Birth: __________________________

Other Legal names (maiden/aliases) used since 1997:

1)____________________ Dates: From_____________ To_________________________
month/year month/year

2)____________________ Dates: From_____________ To_________________________
month/year month/year

How many consecutive years have you lived in Georgia? __________

Please print addresses (including City/State/Zip Code/Dates) for the **PAST 7 YEARS**
(If any additional space is needed, please use separate sheet)

1._______________________________ Dates: From__________ To___________
month/year month/year

2._______________________________ Dates: From__________ To___________
month/year month/year

3._______________________________ Dates: From__________ To___________
month/year month/year

4._______________________________ Dates: From__________ To___________
month/year month/year

Dare of active military service (if applicable or write N/A): From__________ To___________
month/year month/year

The following is required for criminal record identification purposes only:

Date of Birth__________________

Race________________________

Sex_________________________

CONSENT

I hereby authorize Agape Hospice Care, Inc. to receive any criminal history record information pertaining to me which may be in files of any state or local criminal justice agency in Georgia or any other state.

Applicant Signature:__________________________________ Date:______________________