

**Lakeside Hospice, Inc.**  
**P.O. Box 544**  
**Pell City, AL 35125**  
**205-884-1111**

**VOLUNTEER APPLICATION**

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

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

Telephone Home: \_\_\_\_\_ Other: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Education:**

Schools Attended	Dates	Major Subjects	Graduated	Degree

**Employment:**

Employers (begin with most recent)	Dates	Title	Description of Duties

**Religious Affiliation:**

Do you have a religious affiliation?	Yes: _____	No: _____
If yes, name of Church of Community of Faith: _____		

**Health:**

Do you have health related problems or physical limitations?	Yes: _____	No: _____
If so, please explain: _____		
_____		
_____		

**Transportation:**

Do you have access to transportation?	Yes: _____	No: _____
Do you have a valid Driver's License?	Yes: _____	No: _____
Do you have insurance on your vehicles?	Yes: _____	No: _____

**Experience:**

List any skills: direct care, office, arts and crafts, music, interpretation for the deaf, another language, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Categories of Volunteer Services:** (Mark those of interest to you.)

<input type="checkbox"/> Direct Care	<input type="checkbox"/> Transportation	<input type="checkbox"/> Bereavement	<input type="checkbox"/> Language Interpreters
<input type="checkbox"/> Office	<input type="checkbox"/> Arts & Crafts	<input type="checkbox"/> Music	<input type="checkbox"/> Deaf Interpreters
<input type="checkbox"/> Fund Raising	<input type="checkbox"/> Child Care	<input type="checkbox"/> Speaker's Bureau	<input type="checkbox"/> Professional Consultant
<input type="checkbox"/> Special Services: (Please Explain) _____			

**Availability for Volunteer Work:**

Number of days per week: \_\_\_\_\_ Circle days available: M T W T F S S

Circle the times of day you would be available: Morning Afternoon Evening

**Knowledge of Hospice:**

What do you know about hospice care?

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Would you be willing to take Volunteer Orientation Training (4-5 hour course)? Yes: \_\_\_ No: \_\_\_

Would you be willing to participate in Quarterly In-Service Training Events? Yes: \_\_\_ No: \_\_\_

How did you find out about Lakeside Hospice, Inc.? \_\_\_\_\_

**References:** Names of three people we may contact for a personal reference.

Name	Address	Telephone

**Person to contact in emergency**

Name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

**I am willing to make a commitment as an active volunteer for Lakeside Hospice, Inc.**

\_\_\_\_\_  
Signature of Applicant

**Interview:** To be completed by the Interviewer

Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

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