

# Guardian Angel Hospice Volunteer Application

## Contact Information

DATE	
NAME	
ADDRESS	
CITY, STATE AND ZIP	
HOME PHONE	
WORK PHONE	
CELL PHONE	
EMAIL	
DATE OF BIRTH	
Can we text you?	

## Availability:

- weekday mornings       weekend mornings  
 weekday afternoons       weekend afternoons  
 weekday evenings       weekend evenings  
 lets discuss this more

## Comments:

## Which areas are you interested in volunteering:

- Office       Special Events(health fairs etc.)  
 Fundraising       Bereavement Support  
 Respite Care for Patient       Supply delivery for patient  
 recruiting other volunteers

**Summarize any special skills and qualifications you feel you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports. Ex: do you play music? Sing? Like animals?**

How did you hear about Guardian Angel Hospice?

Has anyone in your immediate family died within the last year?

\_\_\_\_\_yes

\_\_\_\_\_no

Please list the name, address and phone number of two references (not related to you):

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(Name) (address) (Phone)

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(Name) (address) (phone)

Have you ever been convicted of a felony or misdemeanor offense?

\_\_\_\_\_no

\_\_\_\_\_yes

Have you ever been terminated from a volunteering or paid position? If yes please provide details

\_\_\_\_\_no

\_\_\_\_\_yes

Are you a veteran or currently serving in any branch of military? We participate in the national program "We Honor Veterans" and you may be able to help. Please let us know if you are/were and what branch

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Person to contact in case of emergency

Name	
address	
city, state, zip	
home phone	
work/cell phone	

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions or other misrepresentations made by me on this application may result in my immediate dismissal. I understand that this information may be disclosed to any party with legal and proper interest and I release Guardian Angel Hospice from any liability whatsoever for supplying such information. I also understand that I will not be paid for my services and this is strictly volunteer work.

Name	
Signature	
Date	

Parent signature if applicant under 18 years old

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Thank you for completing this application and for your interest in being a part of our Volunteer Program.