



Volunteer Registration

Thank you for expressing your interest in becoming a hospice volunteer.

The following information is necessary in making our volunteer assignments and in utilizing your talents and skills to the fullest. We ask that all volunteers make a year commitment to working with our agency.

Questions related to age, gender, religious affiliation and marital status are asked only for purposes of identification and matching volunteers with patient/families. However, volunteers are selected without regard given to these factors.

Complete this registration form and mail to:

Mountain Valley Hospice
108 Steele Avenue, Gloversville, NY 12078

IDENTIFICATION:

Name: _____ Home Phone: _____

Address: _____

Occupation: _____ Full-time: _____ Part-time: _____

Place of Employment: _____

Can we call you at work? Yes _____ No _____ Business Phone: _____

Gender: Male _____ Female _____ Age: 18-35 _____ 36-45 _____ 46-64 _____ 65+ _____

Religious Affiliation: _____

Current Marital Status: _____

Education *(Please check highest level completed)* Field of Study: _____

_____ Some or No High School _____ High School Graduate

_____ Some College/Professional/Tech _____ College/Prof/Tech Graduate _____ Post Grad

EXPERIENCE:

What type of work have you done in the past?

_____ Healthcare _____ Teaching _____ Counseling _____ Other: _____

What are your special skills or hobbies:

- | | | | |
|----------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Teaching | <input type="checkbox"/> Counseling | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Hairdressing | <input type="checkbox"/> Sign Language | <input type="checkbox"/> Music |
| <input type="checkbox"/> Drama | <input type="checkbox"/> Arts & Crafts | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Gardening |

Please specify others: _____

(Form Continues)

HEALTH:

How would you describe your general health in the past year?

Good Fair Poor

Do you have any physical restrictions that might affect your volunteer placement with hospice?

Yes No

Please Specify: _____

NYS Department of Health requires proof of rubella immunization and an annual T.B. test prior to any direct patient assignment. I agree to obtain any appropriate documentation and/or testing to meet this requirement.

Yes No

Have you experienced the loss of a loved one in the past year? Yes No

Please Specify: _____

TRANSPORTATION:

Do you drive? Yes No

Do you have a car at your disposal? Yes No

Are you willing to provide transportation? Yes No

AVAILABILITY:

How often are you available to work as a volunteer?

Once a week Once a month
 Several times a week Several times a month
 Whenever needed

Time of day available:

Morning Afternoon Evening Night

Why do you want to become a hospice volunteer? _____

REFERENCES:

Please list names of people we may contact with your permission for personal reference.

Name: _____

Name: _____

Address: _____

Address: _____

Relationship: _____

Relationship: _____

Occupation: _____

Occupation: _____

Phone: _____

Phone: _____

Signature of Applicant: _____ Date _____

Print Name: _____