HOSPICE VOLUNTEER APPLICATION

Please return via mail to Logan Health Hospice:
275 Corporate Drive, Suite 600 | Kalispell, MT 59901

Personal Information (please print)

Date: ___________________

Name: _______________________ _______________________ _________________
(Last) (First) (Middle Initial)

Address: ____

City: ______________________State: __________________Zip code: _____________

Home Phone: _________________________ Cell Phone: _____________________

Work Phone: _________________________ Email: _________________________

Can receive calls at work: ☐ Yes ☐ No ☐ Emergency Only

Birth date: __________________
(Month and day only)

Veteran ☐ Yes ☐ No
Branch _______________________

Emergency Contact Information

Name: _______________________________ Relationship: ______________________

Home Phone:________________ Work Phone: _______________ Cell:_____________

Education/Training/Special Skills/Licensures or Certificates

____

____

____

____

Work Experience

Organization	How long	Position/Description of Role

Volunteer Experience

Organization	How long	Position/Description of Role

Life Experience

How did you hear of Logan Health Hospice Volunteer Program:

____

Why would you like to volunteer with hospice and what do you hope to gain from this experience:

____

____

____

What qualities (skills/talents/knowledge/experience) do you feel you can bring to Hospice:

____

____

____

Life Experience (continued)

What is your most significant loss and when did it occur:

____

____

____

Have you been with someone at their time of death or cared for someone dying? Please share your experience:

____

____

____

Additional Information you would like to share:

____

____

____

Volunteer Opportunities

Please mark (x) the areas of service that interest you:

Patient/Family Support	Organization/ Support Staff	Specialized/Licensed Care
_____ In Patient's Home	_____ Office Support	____ Massage
_____ In a Care Facility	_____ Special Events	____ Music Therapy
_____ In a hospital	_____ Fund Raising	____ Aroma Therapy
	____ Other_________________	____ Therapy Animal

Your Availability

Weekdays	Weekends	Preferences
____ Mornings ______________	_____ Mornings ______________	_____ Smokers in home ok
____ Afternoons _____________	_____ Afternoons ______________	_____ Pets in home ok
____ Evenings _______________	_____ Evenings _______________	_____ Either patient gender ok
		_____ Any area of the valley ok (Specify area if preferred)

Are you willing to commit to twenty hours of volunteer training and to agree to volunteer for at least one year after the completion of training: _____ Yes _____ No
Comments: ____

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