HOSPICE VOLUNTEER APPLICATION

Email or Mail Completed Application to:

Email : Amanda.Carbajal@kansasvna.org

Mail: Visiting Nurses
c/o Director of Hospice
Clinical Services
200 Maine, Suite C
Lawrence, KS 66044

Questions or to Schedule an Interview:

785-843-3738

Ask for Director of Hospice Clinical Services

PERSONAL INFORMATION

Name _____
Last First MI

Address _____
Number & Street City State Zip

Home _____ Cell_____ E-mail _____

Available to volunteer which of these: circle all that apply

Full Year Only the School Year Only During the Summer Other _____

Weekdays: Morning, Afternoon and/or Evening Hours Weekends : Saturdays and/or Sundays

Automobile available for transportation? ☐ Yes ☐ No

Driver's License and Proof of Auto Insurance will be requested at time of interview and copied for your file.

Type of volunteer service(s) you would like to perform: circle all that apply

Patient Companion Office Support Music Hair Cuts Massage

Outdoor or Handy Help Meal Delivery Weekend Patient Visits at a Care Facility

Other _____

EMPLOYMENT HISTORY OR ATTACH RESUME

Current Employer (if presently employed)_____

Position _____ **Name Supervisor** _____

Contact number _____

Past Employer (within last 2 years) _____

Position _____ **Name Supervisor** _____

Contact Number _____

Reason for leaving _____

VOLUNTEER EXPERIENCE

Organization _____**Time of Service**_____

Position _____ **Name Supervisor** _____

Contact Number_____

Organization _____**Time of Service**_____

Position _____ **Name Supervisor** _____

Contact Number_____

EDUCATION

Highest level of education (circle): High School GED College Other

Other Certificates/Training_____

REFERENCES

- Please list **three references** we may contact,
- List persons who have **known you for at least one year**
- **Do not use people you are related to or whom you live with.**

* If available: **please use one job supervisor** or **volunteer coordinator reference**

Name	Relationship	E-mail (preferred)	Phone

Do we have permission to contact the individuals, employers or volunteer organizations listed above?

☐ Yes ☐ No If no, please explain (on back)

Did you complete this application yourself? ☐ Yes ☐ No If not, who did? _____

Before Applying: Please take time to become familiar with our agency by reviewing our webpage.

Make sure to look at all the information related to our Hospice program by clicking the Hospice tab.

www.kansasvna.org

After Applying, You will be contacted about scheduling an interview. *Thank You*

I authorize the Visiting Nurses to investigate any or all statements contained in this application and to obtain information concerning my qualifications as a prospective volunteer. I authorize my former employers and references listed to make full response to any inquiries made by designated staff members of VNA concerning my previous employment, and my work performance/volunteer experience. I release all such persons and entities from all liability with respect to providing such information to VNA.

I understand that should I be accepted as a volunteer, I will fully adhere to the policies, rules and regulations of the Visiting Nurses. I understand that the Visiting Nurses requires a criminal background check for all volunteers.

I certify that the information contained in this application is true, complete and correct to the best of my knowledge and that any misstatements or omissions in this application may result in VNA's refusal to allow me to work as a volunteer.

VISITING NURSES

_____

Signature / Date