Mary Washington Hospice

MWHC

Volunteer Application

Personal Information

Name: _____ Date: _____

Address: _____

City: _____ State/Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____

Date of birth: ___/___/____ Social Security Number: _____

The best way to contact me is at: ☐ Phone ☐ Email

Person to be notified in case of an emergency: _____

Relationship: _____ Primary Phone Number: _____

Secondary Phone Number: _____

For individuals interested in volunteering directly with patients, we ask for a commitment of up to 4 hours a week. Please indicate your availability below (check all that apply):

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mornings							
Afternoons							
Evenings							

I am a US citizen: ☐ Yes ☐ No

Do you have a valid driver's license? ☐ Yes ☐ No State: _____

I have been a Virginia resident for ___ years

- In the past three years have you been convicted of more than three moving violations?
  ☐ Yes ☐ No
- In the past three years have you been in an accident in which you were found to be at fault? ☐ Yes ☐ No
- In the past seven years have you been convicted of any major driving offense (DWI, reckless driving, etc.)? ☐ Yes ☐ No

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- Have you ever been convicted of any criminal violation of law (including minor traffic violations), or are you now under pending investigation or charges of violation of criminal law? ☐ Yes ☐ No

  If yes, please describe circumstances, date, and jurisdiction: _____

  _____

  _____

  _____

- Have you been the subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agency for either conduct based or performance-based action?

  ☐ Yes ☐ No

  If yes, please explain: _____

  _____

- In the last three years, have you ever knowingly used any narcotics, amphetamines or barbiturates, other than those prescribed to you by a physician? ☐ Yes ☐ No

  If yes, please describe: _____

  _____

Have you ever worked for Mary Washington Healthcare or a Mary Washington Healthcare entity? ☐ Yes ☐ No

Are you eligible for employment in the United States? ☐ Yes ☐ No

If you have relatives employed at Mary Washington Healthcare, please provide their name(s) below: _____

_____

_____

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Education

Level of Education	City and State of Institution	Years of Study	Completed Y/N	Degree or Certification
High School				
Associate Degree				
Bachelor's degree				
Graduate Degree				
Doctorate				
Other(s)				

Professional Licensure:

License/Certification	State	License Number	License Issued	License Expires	Temp or Perm

Experience and Qualifications

Please list your professional skills and/or talents that may support a Mary Washington Hospice patient and/or family member.

1. _____
2. _____
3. _____

Please provide details regarding any life, work and/or volunteer experience that may help you as a hospice volunteer: _____

_____

_____

_____

_____

_____

_____

_____

_____

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Skill Set

Mark all that apply

- Bilingual
- Proficient in ASL
- Computer Skills
- Graphic Design
- Letter Writing
- Microsoft Word
- Grief Counseling
- Patient Care Experience
- Geriatric experience
- Healthcare experience
- Counseling experience
- Other: _____

Volunteer Activities

Please indicate areas of interest to you

Patient and/or Family Care

- Patient/Family Care
- Grief/Bereavement
- Barber/Beautician
- Assorted errands
- Letter Writing
- Active Listening
- Emotional Support
- Childcare
- Geriatric experience
- Patient Care Experience
- Pet Therapy
- Grocery Pickup/drop off
- Life Review
- Recording Life/Legacy
- Light housekeeping
- Other: _____

Programmatic Support

- We Honor Veteran's
- Tuck-in Calls
- Reassurance Calls
- Comfort Catering

Support Opportunities

- Special events
- Community outreach
- Graphic Design
- Administrative assistance
- Computer Skills
- Other: _____

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References

Please list three references that we may contact:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

In what capacity and for how long has this person known you? _____

_____

_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

In what capacity and for how long has this person known you? _____

_____

_____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

In what capacity and for how long has this person known you? _____

_____

_____

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Agreement and Information Release

Please read the following carefully before signing.

I certify that the answers and statements given by me in response to this application are true and correct with out consequential omissions of any kind whatsoever. I agree that Mary Washington Healthcare shall not be liable in any respect if my volunteer position is terminated because I have falsified statements, or answers, or have made omissions on this application or on supporting documentation.

If I volunteer, I hereby agree to abide by the rules and policies of my organization and facilities in which I volunteer as a Hospice Volunteer. I understand that noting contained in the application or during an interview is intended to create a contract between Mary Washington Healthcare and myself for either employment or the provision of any benefits. If a relationship is established, I understand that I have the right to terminate my volunteer position at any time with proper notice, and that Mary Washington Healthcare retains the right to terminate my volunteer position at any time at its discretion. Volunteering is not considered finalized until the Volunteer Coordinator has received:

1. A satisfactory check of references, supporting transcripts and license or registry certification, and criminal background check.
2. A Tuberculosis test must be administered and read,
3. proof of age and citizenship, and all documents necessary to complete federal and state regulatory requirements.

I hereby authorize Mary Washington Healthcare or the appropriate subsidiary to contact any school, listed reference, law enforcement agencies and persons who may aid Mary Washington Hospice determining my suitability for a volunteer position unless otherwise noted. Additionally, I release those individuals and/or organizations contacted from all liability whatsoever for providing the requested information.

Date:_____ Signature:_____

PARENTAL OR GUARDIAN CONSENT

My daughter/son _____ has my permission to serve as a Mary Washington Hospice Teen Volunteer.

SIGNATURE OF PARENT: _____ DATE: _____

Volunteer opportunities are available to all qualified applicants without regard to race, color, religion, gender, national origin, age, disability, or sexual orientation. Hospice shall reserve the right to deny appointment of prospective volunteers as a result of the application, interview and/or training process.