

**VOLUNTEER APPLICATION** 

Adult

Revised March 2014

Telephone: 905-727-6815 Fax: 905-727-1134 Email: info@hospicekingaurora.ca

The purpose of this application is to assist Hospice King-Aurora (HKA) to match volunteers to appropriate assignments. Please note: You are not required to answer any questions below that you are not comfortable answering or may feel are inappropriate. All application are kept strictly confidential and safeguarded against unauthorized access.

Name:		
first name	last name	
Address:		Apt./ Suite:
City:	Postal Code:	
E-mail:		
Phone: Daytime:	Evening Phone:	
Preferred way of being contacted: □phone	□email	
How did you learn about HKA?		
Why do you wish to volunteer at HKA?		
Have you had any personal experience dealing	with end of life illness and/or lo	oss?
Please indicate which HKA volunteer roles you  CLIENT SERVICE VOLUNTEER:	might be interested in: *please	see requirements on Page 3
☐ In-Home Visiting Volunteer ☐ Wellness 1:1 Volunteer (must be certified in a	specific modality ie. Reiki, The	rapeutic Touch, etc.)
Please note modality Wellness <b>Group</b> Volunteer  Bereavement Volunteer		
NON-CLIENT SERVICE VOLUNTEER:  □ Event &/or Fundraising Volunteer		

☐ Administrative Volunteer

—————		pre		.cepting an fixa v			
Do you have a	ny allergies? _						
Do you speak/	read or write i	in a language	e other than Eng	lish?			
For In-Home V	isiting Volunte	eers: Would	you visit a home	with <b>smokers?</b> [	⊒Yes □No	pets? □Yes	5 □No
Please share y	our work expo	erience, inte	rests and/or hob	bies:			
Please list any	special skills,	certificates,	education or qua	alifications you thi	ink may help in	a volunteer	placement:
organization f	or a minimum	of 1 year aft	er training. Do yo	veek and expects ou foresee any dif	ficulty with thi	s commitmei	nt?
Availability	1						
	SUNDAY	Monday	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
MORNING							
AFTERNOON							
EVENING							
Copy of driver' REFERENCES:	l anywhere in o 's license & pro : reference check	our service a of of insuran	rea (King Towns ce is required if c	hip & south Auron driving clients. two people (other t			ave known you
Name		Rela	ationship	Telephone	Email		
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## **VOLUNTEER'S EMERGENCY CONTACT:** Name: Relationship Daytime Phone: Evening Phone \*As an HKA volunteer I am aware of and agree to: All HKA Volunteers: obtain a current and applicable police check: Police Vulnerable Sector Check (client volunteers) & Police Information Check (non-client volunteers) consent to 2 reference checks attend an HKA Orientation session sign an oath of confidentiality & conflict of interest form and volunteer agreement attend (a minimum of 2) continuing education/support meetings per year offered at HKA office or outside agencies. As a Visiting and 1:1 Wellness Volunteer: complete Core Concepts in Palliative Care training by PalCare Network(30 hours) complete Physical Skills & HKA Orientation by HKA Staff As a Bereavement Volunteer: participate in "Bereavement" training relevant to my position I confirm that the information on this application is true and accurate. I authorize Hospice King-Aurora to contact

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

my 2 listed references.