



VOLUNTEER INFORMATION SHEET

Name _____ Date _____

What type of volunteer work do you wish to do?

PATIENT CARE

OFFICE/ADMINISTRATIVE SUPPORT

- ___cooking
- ___cleaning
- ___errands, shopping
- ___child care
- ___yard work
- ___small repairs
- ___respite care
- ___sewing
- ___letter writing
- ___pet care
- ___reading to patient
- ___companionship
- ___provide occasional overnight relief
- ___hair care

- ___assist facilitation with support groups
- ___computer entry
- ___filing
- ___writing notes
- ___photocopying
- ___answering phones
- ___sign language
- ___foreign languages
- ___working at special events
- ___baking for functions
- ___assist with mailings
- ___library work
- ___Heirlooms resale shop
- ___Other _____

How many hours per week are you able to volunteer for Hospice? _____ hours

When are you available?

- ___mornings
- ___afternoons
- ___evenings
- ___some overnights

Which days of the week are best for you? (circle)

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

May we call you at work? Yes No

Restrictions:

- ___no smoking
- ___no cats
- ___no dogs

allergies (name) _____

physical limitations _____

other _____

_____ Every patient you come into contact with may have an infectious disease and not even know it. If you would prefer not to volunteer with the patients we know have an infectious disease, please check here.

Questions or comments you would like us to know:
