



45360 Hodgins Avenue
Chilliwack, B.C. V2P 1P5
Phone: (604) 795-4660
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CLIENT & PATIENT VOLUNTEER TRAINING APPLICATION
CONFIDENTIAL

Personal Information:

Date: _____

First Name: _____ Middle Name: _____ Surname: _____

Address: _____ Postal Code _____

Home Phone: _____ Other Phone: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Other Phone: _____

Date of Birth: _____ (year/month/day)

Can we share your contact information with other Hospice Volunteers? Yes No

I grant permission for photographs/videos, written evaluation comments, or interviews to be used for educational purposes and/or to promote the Programs and Services of the Chilliwack Hospice Society? Yes No

Education/Special Training:

Work Experience during the past five years:

Do you have a car or access to transportation? Yes No

Do you speak a language other than English? Yes No

Language: _____ Speak _____ Read _____ Write _____

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How did you hear about our Hospice Volunteer Programs and Services?

Why do you want to be a Hospice Volunteer?

What personal qualities (skills, knowledge and experiences) do you have that will help you in the work you will do as a hospice volunteer?

Have you experienced the loss of a loved one in the past 12 months? Yes No

If so, please explain:

What are your thoughts and feelings about death?

Have you ever been with someone at the time of their death?

When thinking of your own death, what words best describe death to you?

I do not think about my own death Sorrowful Natural Frightening Painful

Lonely Joyful Heavy Peaceful Dark

Other:

REFERENCES: 3 are required - 1 from your current or most recent employer/supervisor; and 2 people who are not immediate family and who have known you for at least three years.

Name	Contact Number	Relationship

Code of Ethics for Volunteers

As a volunteer, I realize that I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume certain responsibilities and expect to account for what I do in terms of what is expected of me. I understand that any information which is disclosed to me while volunteering with the Chilliwack Hospice Society is confidential.

I interpret “volunteer” to mean that I have agreed to work without compensation in money. I understand that I will be required to complete a police record check, meet with the Palliative Services & Education Coordinator and successfully complete the 30 hour volunteer training before being accepted as a Client and Patient Volunteer. It should be noted; however, that even after completion of the volunteer training, not everyone is accepted as a volunteer.

Declaration

I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application I authorize enquiries to be made concerning my employment, character and public records for the purpose of determining my suitability as a volunteer. I agree to respect the confidentiality of any client information I acquire in the course of my volunteer activities with the Chilliwack Hospice Society.

Applicant’s Signature

Date

For Office Use:

Date Received: _____

Interview date/time: _____