



Atlantic Visiting Nurse
200 Mt. Airy Road, Basking Ridge, N.J. 07920

Hospice Volunteer Application

(Please Print)

Name of Applicant _____ Birthday (year optional) ___/___/___

Address _____ City _____ Zip _____

Home/Cell Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

E-mail _____

Occupation _____ Employer _____

Can you receive calls at work? [] YES [] NO [] Emergency Only

Education/Special Training _____

Work Experience _____

Please provide TWO Personal References (excluding family members). Please provide a complete address, as references are verified by mail.

First Name _____ Last Name _____ Phone _____ - _____ - _____

Address _____ City _____ State ___ Zip _____

First Name _____ Last Name _____ Phone _____ - _____ - _____

Address _____ City _____ State ___ Zip _____

Identified Areas of Interest:

Form with checkboxes for Patient/Family Care, Bereavement, and Non-Patient Services.

Do you know a language other than English? [] YES [] NO

Language _____ [] Speak [] Read [] Write

Other Special Services: (manicurist, hairdresser, masseuse, etc.) _____

Do you have access to transportation? [] YES [] NO

Liability Insurance? [] YES [] NO

Valid Driver's License? [] YES [] NO

Days and Hours available to Volunteer:

- Monday Morning Afternoon Evening
- Tuesday Morning Afternoon Evening
- Wednesday Morning Afternoon Evening
- Thursday Morning Afternoon Evening
- Friday Morning Afternoon Evening
- Saturday Morning Afternoon Evening
- Sunday Morning Afternoon Evening
- Holidays Morning Afternoon Evening

Person to be notified in an emergency:
First Name _____ Last Name _____ Phone _____ - _____ - _____
Address _____ City _____ State ____ Zip _____

How did you learn about the Atlantic Visiting Nurse Hospice Volunteer Program?

What do you think you will gain from volunteering for Hospice Volunteer Program?

What do you think you will be able to contribute to the Hospice Volunteer Program?

What qualities (*skills, talents, knowledge, and experiences*) do you feel you can incorporate into your hospice volunteer work?

Death and Dying

What are your thoughts and feelings about death?

Have you ever been with someone at the time of their death? YES NO

If YES, please briefly describe your experience: _____

Have you ever provided care to anyone who was dying? YES NO (*If YES, please explain*)

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: _____

Comments: _____

Have you ever been convicted or plead guilty to a crime or criminal offense, other than a minor traffic violation, which has not been expunged or sealed by a court? YES NO (*If YES, please explain*)

You should be available at least two hours per week when you have a patient assignment.

Please read the information below carefully and **sign** the application

I realize, as a condition of volunteering, that I will be required to undergo a physical examination as prescribed by the Agency prior to being assigned patients. I understand that I may not be accepted as a volunteer if the results of that physical examination reveal that I may not be able to perform my duties without endangering my own health and safety, or the health and safety of others.

X _____ Date ____/____/____
(Signature of Applicant)



Atlantic
Health System

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 that is disclosed to me while assisting the Atlantic Visiting Nurse is confidential.

I interpret "volunteer" to mean that I have agreed to work without compensation in money. Having been accepted as a volunteer worker, I expect to do my work according to the standards set forth in the Volunteer Policies and Procedures.

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 inquiries to be made concerning my employment, character and public records for the purpose of determining my suitability as a volunteer. I affirm that I have read the volunteer Code of Ethics and agree to abide by its regulations. I agree to respect the confidentiality of any client information I acquire in the course of my volunteer activities with Atlantic Visiting Nurse.

Applicant Signature

Date