



Arkansas Hospice Foundation, Inc.

# ARKANSAS HOSPICE RESALE SHOP VOLUNTEER APPLICATION

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (cell): \_\_\_\_\_

E-mail \_\_\_\_\_

Current Employer, if applicable \_\_\_\_\_

Civic/Prof'l membership \_\_\_\_\_

Language(s) spoken...other than English \_\_\_\_\_ Birthday (mth) \_\_\_\_\_ (day) \_\_\_\_\_

- ✓ How did you learn of *Arkansas Hospice*? \_\_\_\_\_
- ✓ In general, volunteers commit 3-4 hours every week. What is your preferred availability:  
days: \_\_\_\_\_ hours: \_\_\_\_\_
- ✓ When are you able to start? \_\_\_\_\_
- ✓ Can you commit to volunteering for 3 months or longer? \_\_\_\_\_ If not, what length of time? \_\_\_\_\_
- ✓ Emergency Name/Number \_\_\_\_\_

### PERSONAL REFERENCES

Name:	Name:
Address:	Address:
Occupation:	Occupation:
Phone:	Phone:
Relationship:	Relationship:

Complete this application and return to Arkansas Hospice:

- by mail:** Arkansas Hospice Foundation Resale Shops, 5600 W 12<sup>th</sup> Street, Little Rock, AR 72204
- by fax:** (501)748-3457, Attn: Director of Resale Shops
- in person:** to the Resale Shop at 5600 W 12<sup>th</sup> Street during business hours Monday-Saturday

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Thank you for your interest! We will be contacting you soon.*  
www.arkansashospice.org