



Send Application to:
Harriet Hawkins
14 Parkstone Circle
North Little Rock, AR 72116
Or Fax: 501-748-3334

Name _____

Address: _____ City _____ Zip _____

Phone (Home) _____ (Work) _____ (Cell) _____

E-mail _____ Fax _____

Employer _____ Occupation _____

Employer's Address _____

Education _____ Civic/Professional membership: _____

Marital Status _____ Spouse Name _____

Social Security # _____ Drivers License # _____

Language(s) Spoken...other than English _____ Birthday (month) _____ (day) _____

Other Special Skills/Training: _____

Please answer the following questions

1. How did you learn about *Arkansas Hospice*? _____

2. Are you familiar with the philosophy and concept of hospice care? Yes No

3. In which capacity do you wish to volunteer?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Direct Patient Care | <input type="checkbox"/> Bereavement | <input type="checkbox"/> Phone Reception |
| <input type="checkbox"/> Office Work | <input type="checkbox"/> Fund Raising | <input type="checkbox"/> Data Input |
| <input type="checkbox"/> Available as Interpreter | <input type="checkbox"/> Other | |

Available Hours per week _____ Days Evenings Weekends

Please share any life experiences or personal characteristics that especially qualify you for hospice work:

Emergency Name/Number: _____
2nd Emergency Name/Number _____

Signature

Date

PERSONAL REFERENCES:

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

Name _____
Address _____
Occupation _____
Phone _____
Relationship _____

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

FOR OFFICE USE ONLY

Proof of Insurance: _____ Yes _____ No Comments: _____

Volunteer Training Date/Trainer _____

Reference #1 Checked _____ Comments _____

Reference #2 Checked _____ Comments _____

Reference #3 Checked _____ Comments _____