Crossroads HOSPICE SOCIETY
Comfort • Compassion • Dignity

Palliative Care Support Volunteer Application Form

Please **print** clearly and mail, email or fax back to the address below.

PERSONAL INFORMATION **DATE**:_____

Name:_____ Date of Birth:_____

Address:_____City:_____Postal Code:_____

Phone:_____ Work/Cell #:_____ Email:_____

Do you have previous volunteer experience with Crossroads?_____

Have you volunteered elsewhere? ❑ Yes ❑ No Where?_____

Please list your skills:_____

Do you speak other languages?_____

How many hours per week can you volunteer? ❑ 2 hours ❑ 4 hours ❑More than 4 hours

All volunteers are required to make a commitment of a minimum 2 hour shift per week for one year.

What city would you like to perform your volunteer activities?

❑ New Westminster ❑ Tri-Cities

I am interested in the following areas (please check all that apply)

IN HOSPICE OR COMMUNITY

❑ Visiting Volunteer	❑ Tea Service	❑ Art Cart
❑ Administration	❑ Gardening	❑ Bereavement

AVAILABILITY

❑ Monday	❑ Tuesday	❑ Wednesday
❑ Thursday	❑ Friday	❑ Saturday
❑ Sunday	❑ Weekends	❑ Week days
❑ Mornings	❑ Afternoon	❑ Evenings

1. Have you had any close, personal deaths in the last two (2) years?

   _____

   _____

2. Are you presently involved in any major life transitions?

   _____

   _____

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Please read the following carefully before signing this application:

By signing, I confirm that the information in this volunteer application is complete and true. I understand and agree that any omission or misrepresentation may be cause for refusal of volunteer placement, or if I am a volunteer for Crossroads Hospice Society, may be cause for immediate termination. I understand that a Criminal Record Check will be required.

I also understand that by signing this volunteer application form, Crossroads Hospice Society will keep a record of my personal information on site and that it will remain confidential to Crossroads Hospice Society. I understand that this information may be disclosed to any party with legal and proper interest and release Crossroads Hospice Society from any liability whatsoever for supplying such information.

Signed: _____ Dated: _____

Fax, Drop-Off, Email, or Mail your volunteer application or contact us for more information.

FOR OFFICE USE ONLY:
Interviewed by:
Orientation:
Data entry by

Crossroads Hospice Society
Suite # 504 – 34A – 2755 Lougheed Highway,
Port Coquitlam, BC V3B 5Y9
Tel: 604-945-0606 • Fax: 604-945-9071
info@crossroadshospice.org www.crossroadshospicesociety.com