

Comfort Hospice, Inc.

VOLUNTEER APPLICATION FORM

Thank you for your interest in volunteering with Comfort Hospice, Inc. Please complete all sections fully and accurately. All information is kept strictly confidential.

SECTION 1 — PERSONAL INFORMATION

			Application Date: _____	
Last Name	First Name	Middle Name	Preferred / Nickname (optional)	
Street Address	City	State	ZIP Code	County
Date of Birth (MM/DD/YYYY)	Home Phone	Cell Phone	Work Phone	Email Address
Emergency Contact Information				
Full Name	Relationship to Applicant	Phone Number		

SECTION 2 — BACKGROUND & MOTIVATION

How did you learn about volunteering with Comfort Hospice, Inc.? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Personal hospice care experience | <input type="checkbox"/> Community outreach event |
| <input type="checkbox"/> Radio / Newspaper / Local publication | <input type="checkbox"/> Comfort Hospice website |
| <input type="checkbox"/> Television | <input type="checkbox"/> Referred by a staff member, friend, or volunteer |
| <input type="checkbox"/> Speaker or group presentation | <input type="checkbox"/> Other (describe below) |

If referred or other, please specify: _____

Is volunteer service required by your school or community organization? Yes No

If yes, please explain briefly: _____

Are you a U.S. military Veteran? Yes No

If yes, which branch of service? _____

Have you experienced a significant personal loss within the past 12 months? Yes No

If yes, please briefly describe: _____

Why are you interested in volunteering with Comfort Hospice, Inc.? _____

SECTION 3 — VOLUNTEER INTERESTS

Direct Patient & Family Support (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Home visits | <input type="checkbox"/> Nursing facility visits |
| <input type="checkbox"/> Inpatient / Hospice House support | <input type="checkbox"/> Comfort vigil sitting |
| <input type="checkbox"/> Life story & legacy reviews | <input type="checkbox"/> Meal preparation / serving |
| <input type="checkbox"/> Welcoming & greeting guests | <input type="checkbox"/> Yard work & outdoor maintenance |
| <input type="checkbox"/> Haircuts & personal grooming | <input type="checkbox"/> Sewing & mending |
| <input type="checkbox"/> General repairs & fix-it projects | <input type="checkbox"/> Errands & shopping assistance |
| <input type="checkbox"/> Massage therapy (license required) | <input type="checkbox"/> Pet therapy (certification required) |
| <input type="checkbox"/> Pet care assistance program | <input type="checkbox"/> Veteran recognition & honor program |

Bereavement & Grief Support (check all that apply)

- Bereavement phone outreach
 Bereavement home visits
 Grief support group facilitation

Spiritual & Pastoral Care (check all that apply)

- Spiritual care phone support
 Spiritual care home visits

Administrative & Organizational Support (check all that apply)

- Office / clerical support (Mon–Fri, 8:30 AM–4:30 PM)
 Donor relations & stewardship
 Special events & community projects

Computer skills (circle all that apply): Word Processing | Spreadsheets | Presentations | Data Entry

Skills, talents & hobbies you would like to contribute (e.g., music, arts & crafts, professional expertise, languages):

Do you speak a language other than English? Yes If yes, which language(s)? _____
 No

Do you know American Sign Language (ASL)? Yes No

SECTION 4 — AVAILABILITY & TRANSPORTATION

When are you generally available? (check all that apply)

- Mornings
 Afternoons
 Evenings
 Weekends
 Flexible
 Seasonal only

Preferred days of the week:

- Sunday
 Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday

Estimated hours available per week: _____

Which service areas are you willing to travel to? (check all that apply)

- Lake County
 Sumter County
 Orange County
 Osceola County
 Polk County
 Hardee County
 Highlands County

Reliable personal transportation? Yes No
 Valid driver's license? Yes No
 Current auto insurance? Yes No

Do you have any medical conditions, physical limitations, allergies, or other health concerns that could affect your ability to perform volunteer duties? Yes No

If yes, please describe:

SECTION 5 — EMPLOYMENT BACKGROUND

Are you currently employed? Yes No
 Are you retired? Yes No

Current or most recent job title / profession:

If currently employed, please complete the following:

Employer / Organization Name	Work Phone	Extension
Street Address	City	State
		ZIP Code

SECTION 6 — EDUCATIONAL BACKGROUND

Please indicate the highest level of education completed:

Level	Years Completed	School / Institution	Field of Study / Major
High School / GED	1 2 3 4		N/A
College / University	1 2 3 4		
Graduate / Post-Graduate	1 2 3 4		

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VOLUNTEER APPLICATION — PERSONAL REFERENCES

Please provide three personal references who are not family members. Each reference must be at least 18 years of age. All fields must be completed for your application to be reviewed.

Applicant's Full Name: _____

Reference 1

Full Name	Relationship to Applicant		
Street Address			
City	State	ZIP Code	
Phone Number	Email Address		

Reference 2

Full Name	Relationship to Applicant		
Street Address			
City	State	ZIP Code	
Phone Number	Email Address		

Reference 3

Full Name	Relationship to Applicant		
Street Address			
City	State	ZIP Code	
Phone Number	Email Address		

Important Notice: All volunteers approved for direct patient contact are required to complete a two-step tuberculosis (TB) screening test and a comprehensive Level 2 background check, which includes fingerprinting, before beginning service.

Applicant Certification

By signing below, I affirm that all information provided in this application is true and complete to the best of my knowledge. I understand that any misrepresentation may result in the denial of my application or termination from the volunteer program.

Applicant Signature	Date
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For Office Use Only — Date Received: _____ Processed by: _____ Background Check: _____
TB Test: _____

