



P.O. Box 1376, Mount Vernon, WA 98273

Phone: 360-416-5702

Fax: 360-428-8222

Web: www.skagithospicefoundation.com

E-mail:

info@skagithospicefoundation.com

Volunteer Information

Name: _____

Address: _____

City: _____ State: _____

Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Best way to contact you weekdays/daytime: (please check all that apply)

Home Phone: _____ Cell Phone: _____ Work Phone: _____ E-mail: _____

Occupation: _____ Are you available weekdays? _____

Do you have a Washington State Drivers License? Yes: _____ No: _____

I am 21 or over: _____ I am under 21: _____

In an emergency notify: _____

Relationship: _____ Phone: _____

Cell Phone: _____ Work Phone: _____

Why are you interested in being a Skagit Hospice Volunteer?

What are your hobbies, talents, skills, and interests?

Do you have any prior volunteer experience? _____

Have you experienced a personal loss recently? _____

Do you know someone who has received hospice care? _____

Education or specialized training: _____

Degree or Certificate: _____

Do you speak any foreign languages? _____ If yes, please specify: _____

How did you hear about Skagit Hospice? Friends/Family: _____ Newspaper: _____

Radio: _____ Flyer: _____ Internet: _____ Other: (please specify) _____

What are your areas of interest: Organizational? Patient Care? and/or Therapy?

Organizational Volunteer

I am interested in being an Organizational Volunteer: Yes: _____ No: _____

Please check all you are interested in: Mailings: _____ Delivery: _____ Courier: _____

Filing: _____ Receptionist: _____ Typing: _____ Library: _____ Telephoning: _____

Special Events: _____ Other: (please specify) _____

Computer Proficiency: Data Entry: _____ Word Processing: _____ Other: _____

Patient Care Volunteer

I am interested in being a Patient Care Volunteer: Yes: _____ No: _____

I would like to provide: Companionship: _____ Respite: _____ Transportation: _____ Errands: _____

Therapy Volunteer

I am a licensed therapist and would like to provide the following:

Massage: _____ Music Therapy: _____ Acupuncture: _____ Chiropractic: _____

Or other therapeutic therapy: (please specify) _____

I certify that the information I provided on this volunteer application is true and complete to best of my knowledge.

Signature: _____ Date: _____