HospiceCare
in The Berkshires, Inc.
A Member of Berkshire Healthcare
Managed by an Affiliate of Berkshire Health Systems

Patient Care Volunteer Application

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____

Cell Phone _____ E-mail address _____

How did you learn about HospiceCare?_____

_____

Education/ Special Training

_____

_____

Field of Professional License/Credentialing or Certification _____

Work Experience

_____

_____

_____

Past or present volunteer experiences (Agencies, Dates)

_____

_____

_____

What qualities (*skills, talents, knowledge and experiences*) do you feel you can incorporate into your hospice volunteer work?

_____

_____

_____

Death & Dying

What are your thoughts and feelings about death? _____

_____

_____

Have you ever been with someone at the time of their death? ❑ No ❑ Yes (*If yes, please explain*)

If yes, please describe briefly and how recent:_____

Have you ever provided care to anyone who was dying? ❑ No ❑ Yes (*If yes, please explain)*

_____

_____

Why do you want to become a HospiceCare volunteer? _____

_____

References (Please list two references other than family members)

Name _____ Name _____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

Relationship to reference _____ Relationship to reference _____

_____ _____

_____ _____

Signature **Date**