



HOSPICECARE

in The Berkshires, Inc.



A Member of Berkshire Healthcare
Managed by an Affiliate of Berkshire Health Systems

Volunteer Application

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____

Cell Phone _____ E-mail address _____

How did you learn about HospiceCare? _____

Volunteer Preference: (please circle): *Patient Family Volunteer* or *Administrative Volunteer*

Education/ Special Training

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