HARBOR GRACE
Hospice

Volunteer Job Description

Under the supervision of the Volunteer Coordinator, Harbor Grace Hospice volunteers provide support and assistance to patients, families and staff. There are two categories of volunteers:

- Direct Care Volunteers
- Indirect Care Volunteers

Qualifications For All Volunteers:

- Ability to listen and communicate well with others.
- Sensitivity to the dying process and empathy for how it affects our patients and their families.
- Ability to provide one's own transportation as well as proof of a valid driver's license, proof of car insurance and an M.V.R..
- Compliance with a background check.
- To have a positive and friendly attitude.

Responsibilities of Direct Care Volunteers:

- Provide non-medical services to patients and families (ie: companionship, conversation, transportation, meal preparation, feeding a patient, reading to a patient, running errands and light housekeeping).
- Participate in staff-sponsored activities for grieving families (ie: memorial services).
- Documentation of services provided.
- Report directly to the Volunteer Coordinator.

Responsibilities of Indirect Care Volunteers:

- Answering and making telephone calls
- Filing, organizing and mailings
- Documentation of services provided
- Report directly to the Volunteer Coordinator.

I have read and I understand the job description for Harbor Grace Hospice Volunteers.

Volunteer Signature: ______________________________ Date: ____________

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VOLUNTEER APPLICATION

DATE: ____________________

NAME: ____ BIRTHDAY: ________________

ADDRESS: ____

CITY: ____________________ STATE: ____________________ ZIP CODE: ________________

CELL #: __________________ HOME #: ___________________ WORK #: ___________________

OCCUPATION: ______________________ CURRENT EMPLOYER: ___________________________

VOLUNTEER EXPERIENCE: ____

____

SPECIAL TRAINING/SKILLS: ____

____

EDUCATION:

HIGH SCHOOL: ____

CITY: ____________________ STATE: ____________________ DEGREE: __________________

YEARS ATTENDED: __________________ YEAR OF GRADUATION: _____________________

COLLEGE/UNIVERSITY: ____

CITY: ____________________ STATE: ____________________ DEGREE: __________________

YEARS ATTENDED: __________________ YEAR OF GRADUATION: _____________________

POST-GRADUATE SCHOOL: ____

CITY: ____________________ STATE: ____________________ DEGREE: __________________

YEARS ATTENDED: __________________ YEAR OF GRADUATION: _____________________

Have you ever been convicted of a felony or a misdemeanor? ____________ YES ____________ NO

If yes, please explain: ____

CATEGORIES OF VOLUNTEER SERVICE (indicate your interest):

________ Patient Companion ________ Bereavement Team ________ Office Work

AVAILABILITY (indicate times available for each day):

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

REFERENCES (2 personal, 1 professional):

NAME: ______________________ PHONE #: __________

ADDRESS: ______________________

CITY: __________ STATE: __________ ZIP CODE: __________

NAME: ______________________ PHONE #: __________

ADDRESS: ______________________

CITY: __________ STATE: __________ ZIP CODE: __________

NAME: ______________________ PHONE #: __________

ADDRESS: ______________________

CITY: __________ STATE: __________ ZIP CODE: __________

May we contact the references listed above? __________
Are you willing to provide additional information/references if deemed necessary? __________

How did you hear of Harbor Grace Hospice? ______________________

Why do you want to be a Hospice Volunteer? ______________________

Have you ever experienced the death of a family member or a close friend? __________

If so, when and please explain the circumstances: ______________________

Have you ever experienced Hospice with a family member or a close friend? __________

If so, when and please explain the circumstances: ______________________

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EMERGENCY CONTACT INFORMATION

VOLUNTEER NAME: ______________________________

PRIMARY EMERGENCY CONTACT:

NAME: ______________________ **RELATIONSHIP:** ______

ADDRESS: ______________________________________

CITY: __________ **STATE:** _________ **ZIP CODE:** ________

CELL #: ________ **HOME #:** ________ **WORK #:** _________

SECONDARY EMERGENCY CONTACT:

NAME: ______________________ **RELATIONSHIP:** ______

ADDRESS: ______________________________________

CITY: __________ **STATE:** _________ **ZIP CODE:** ________

CELL #: ________ **HOME #:** ________ **WORK #:** _________

PHYSICIAN:

NAME: ______________________ **PHONE #:** __________

ADDRESS: ______________________________________

CITY: __________ **STATE:** _________ **ZIP CODE:** ________

TUBERCULIN SKIN TEST (PPD)

All new employees/volunteers are required to receive the TB skin test in **two steps.** Should the employee provide documentation of a negative TB given within the previous twelve months then the **one step** will be acceptable. The previous TB test **must** be attached. The form is also for the **Annual One-Step TB Test.**

Employee Name:

Step One Test given by: ______________________________

Date: __________

Results (48-72 hours after given): ____________ Negative ____________ Positive

Read by (RN/LPN): ______________________________

Date: __________

The **Step Two Test** should be given within 7-21 days from the **Step One Test.**

Step Two Test given by: ______________________________

Date: __________

Results (48-72 hours after given): ____________ Negative ____________ Positive

Read by (RN/LPN): ______________________________

Date: __________

If the skins test is **positive,** a chest x-ray will be required and the employee referred to a physician or appropriate health authority for possible prophylaxis treatment.

The Annual One-Step TB Test will be supplied and maintained by Harbor Grace.

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EMPLOYEE/VOLUNTEER HEALTH QUESTIONNAIRE

Full Name: ______________________________ Age: _____ Sex: _____
Address: ______________________________ DOB: __________
City: __________ State: __________ Zip Code: __________ Phone #: __________
Name of Physician: ______________________________ Date of Last Visit: __________
Physician Address: ______________________________
City: __________ State: __________ Zip Code: __________ Phone #: __________

DO YOU HAVE A FAMILY HISTORY OF:

__________ Nervous/Mental Illness __________ Diabetes __________ Tuberculosis

Have you had or do you have any of the following? (If yes, check after each of the following)

DISEASE OF THE:			
Brain	Dizziness	Vomiting Up Blood	Bronchitis
Eyes	Freq. Headaches	Stomach Ulcers	Nephritis
Ears	Deafness	Chronic Constipation	Malaria
Nose	Running Ears	Black/Bloody BMs	Rheumatic Fever
Throat	Fainting Spells	Freq./Painful Urination	Paralysis
Heart	Chest Pains	Blood In Urine	Cancer
Lungs	Freq. Sore Throat	Swollen Ankles	Tumors
Stomach	Freq. Colds	High Blood Pressure	Asthma
Intestines	Shortness of Breath	High Cholesterol	Hay Fever
Liver	Chronic Cough	Jaundice	Diabetes
Spleen	Coughing Up Blood	Hernia	Arthritis
Gallbladder	Palpitations	Pneumonia	Rheumatism
Kidneys	Allergies	Pleurisy	Nervous Breakdown
Bladder	Poor Appetite	Kidney Stones	Painful Flat Feet
Bone	Chronic Indigestion	Piles	Backaches
Joints	Recurrent Nausea	Fits/Convulsions	Chronic Sinus Infections
Back (Spine)	Recurrent Vomiting	Tuberculosis	
Skin			
Lymph Nodes			
Genitals			

Have you ever been rejected or discharged from military services because of an illness/injury? __________
If yes, please explain: ______________________________
Have you ever received any pension, insurance payments, or compensation for an injury or illness? _____
If yes, please explain: ______________________________
In case of an accident/emergency, are you currently taking any medications? __________
If yes, please explain: ______________________________
State details of any medical allergies that you may have: ______________________________
State details of any illnesses, injuries, operation, or defects; current or past: ______________________________

I, the undersigned, certify that the above answers are true, and give the examining physician permission to submit a report to Harbor Grace Hospice.

Volunteer Signature: ______________________________ Date: __________

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EMPLOYEES/VOLUNTEERS DRIVING PERSONAL VEHICLES ON COMPANY BUSINESS

Name of Driver: ______________________________ Date of Birth: ______________

Address: ______________________________________ License: _____ Temp _____ Perm

City: ____________________ State: ______________ Zip Code: ______________

Driver's License No.: ___________ Issuing Date: __________ Expiration Date: __________

Position with Harbor Grace Hospice: **Volunteer**

Does the license meet the legal requirements for the type of vehicle to be driven? ______________

Are there any restrictions specified on the license relating to driving activity (eyeglasses, daylight driving only, etc.)? ____

Average Monthly Business Miles: __________ 0-100 __________ 101-500 __________ Over 500

THE EMPLOYEE UNDERSTANDS THAT THEIR OWN AUTOMOBILE INSURANCE PROVIDES PRIMARY INSURANCE COVERAGE WHEN THEIR PERSONAL AUTOMOBILE IS USED ON COMPANY BUSINESS.

It is recommended that the employee contact his/her insurance agent if there is question concerning adequacy of the insurance. The signature below verifies that all of the above driver information is correct as stated and Harbor Grace Hospice has the right to order a Motor Vehicle Report (MVR).

Volunteer Signature: ____________________________________ Date: __________

Supervisor Signature: ____________________________________ Date: __________

VOLUNTEER'S AUTOMOBILE RELEASE OF LIABILITY

It is my understanding that, as a volunteer, it is not a requirement that I transport patients in my vehicle. However, should I make the decision to transport a patient in my vehicle:

I acknowledge that I have the primary and sole responsibility for my vehicle insurance. I agree to hold Harbor Grace Hospice and its agents harmless in the event that there is any type of accident in which there is damage of any sort to my vehicle or to property of other or injury to myself or to any persons, including vehicle occupants, except as covered by Worker's Compensation law.

I agree to maintain insurance coverage at levels consistent with Harbor Grace Hospice Services recommendations and to provide the agency with proof of insurance coverage. I acknowledge that I have primary and sole responsibility for my automobile safety and maintenance. I agree to keep my automobile in safe operating condition and to comply with all driving and traffic laws.

Volunteer Signature: ____________________________________ Date: __________