Redmond ~ Sisters
HOSPICE
Earning Trust... Inspiring Courage

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Redmond, OR 97756
541-548-7483

204 W Adams St., Ste. 117
Sisters, OR 97759
541-549-6558

Toll Free:
1-877-244-0858

Hospice & Transitions VOLUNTEER APPLICATION

Mission Statement:

Redmond-Sisters Hospice is committed to enhancing the quality of life for persons with life threatening conditions, and. their families, in Central Oregon.

Date _____/_____/_____

The Hospice & Transitions volunteer programs often receive requests for volunteers with specific skills or interests such as: the ability to speak a foreign language; carpentry skills; signing for the deaf; quilting; cooking and more.

The following in-depth application is designed to provide the information Redmond - Sisters Hospice needs to effectively match volunteers to patients and families.

ALL INFORMATION PROVIDED BY APPLICANT IS CONFIDENTIAL

Personal Data

Name ____
Last First MI

Address ____
Street PO Box

City ___________________________ST________Zip____________

Phone ( )_________________(H) ( )________________(B)

Cell: ____________________ Email: _______________________
(Business, cell # and Email information is optional)

Birthday: **Month_________Day________**

Emergency Contact: Name____

Phone(s) _________________________________

Licensed Driver? ◘ Yes ODL #__________________ ◘No

Insurance Co______________________Policy # ___________________

What brings you to Hospice & Transitions? Personal Experience
Friend Professional Contacts Newspaper Church

Other ____

Are you a relative or friend of a Hospice patient or a Transitions client?
Yes No

What do you consider the strongest attributes/skills that you will bring to our programs?

Why do you want to become a Hospice and/or Transitions volunteer?

What support systems do you have to help you through a Hospice or Transitions volunteer experience?

Have you experienced a personal loss in the past year? ◻ Yes ◻ No

If yes, please tell us about the loss:

What past life experiences do you feel will be helpful to you as a Hospice or Transitions volunteer?

Have you worked with dying patients either personally or professionally? ◻ Yes ◻ No

If yes, please give a brief history

Are you available to volunteer or at least one year following training?

What are your thoughts about working with patients near your own age and/or dying children?

Areas of Volunteering and Involvement: Please check areas that interest you most (check all that apply)

PATIENT/FAMILY CARE

- ◊ Adults
- ◊ Children
- ◊ HIV/Aids patients
- ◊ Nursing Home, ALF,AFH
- ◊ Errands/Delivery
- ◊ Telephone Calls
- ◊ Volunteer on Call (weekends)
- ◊ Bereavement
- ◊ Respite
- ◊ Vigil
- ◊ Transitions
- ◊ Transportation/driving
- ◊ Other ___________________

SPECIAL EVENTS

- ◊ Camp Sunrise (kids' grief camp)
- ◊ Festival of Trees
- ◊ Social Events
- ◊ Memorial Celebrations
- ◊ Other ___________________

INDIRECT INVOLVEMENT:

- ◊ Fund Raising
- ◊ Public Relations - Hospice Ambassador, community presentations, etc.
- ◊ Volunteer Recruitment/Training
- ◊ Assist with meetings, seminars, workshops & conferences
- ◊ Library and resource center maintenance
- ◊ Receptionist
- ◊ General Office, Administration
- ◊ General Maintainance
- ◊ Lawn & Garden
- ◊ Computer Work
- ◊ Cooking & baking
- ◊ Other ______________________________________

As a patient/family care volunteer, are you able to respond to last-minute requests?

◻ **Yes** ◻ **No**

Your patient only? ◻ **Yes** ◻ **No**

Number of hours per week you might be available:___________

Are you available: ◻ Days ◻ Evenings ◻ Weekends

Would you prefer to work with another volunteer to provide back-up support?
◻ Yes ◻ No

Are you available on short notice for temporary assignments/respite? **Y** **N**

Do you mind being around : Children **Y** **N**; Animals **Y** **N**; Smokers **Y** **N**

Your Profession/Interests/Hobbies

□ Professional □ Farm/Ranch □ Teacher □ Forest Service □ Military □ Trade □ Musician

□ Computer/Tech □ Accountant □ Homemaker □ Construction □ Medical Other

____

Religious Preference

Are you a church member?

- Yes
- No

If yes, which church?

____

If no, do you have any religious preferences?

____

____

Activities

□ Cards
□ Games
□ Sports
□ Hunting
□ Fishing
□ Hiking/walking
□ Canoeing/kayaking
□ Traveling
□ Other

____

____

____

____

Skills/Talents/Interests

□ Painting
□ Writing
□ Signing
□ Reading
□ Gardening
□ Dance
□ Computer
□ Other (please list)

□ Animals
□ Arts/Crafts
□ Needlework
□ Music
□ History
□ Woodworking

______________ ______________

______________ ______________

Do you have any physical limitations?
Yes **No**
If yes, please explain:

Personal References: Please provide a complete mailing address with zip code.

Name______________________________Address_______________________________________Phone__________

Name______________________________Address_______________________________________Phone__________

Name______________________________Address_______________________________________Phone__________

All patient care volunteers MUST have yearly proof of a TB skin test in order to volunteer in patient homes. You will be given a TB skin test during training if you haven't been tested recently.

Date of your last TB test:__________________________ (Not applicable to non-patient care volunteers)

Redmond - Sisters Hospice STATEMENT OF CONFIDENTIALITY:

I understand that the condition, care and treatment of the patients and families of Redmond - Sisters Hospice must be held in strict confidence by all staff, volunteers and board members. This obligation of confidentiality must be carefully fulfilled not only regarding the information on the patient's charts and records, but also regarding confidential matters learned in the course of professional and/or volunteer duties. Under no circumstances may I discuss this information with anyone, even the patient's family or friends, unless I am authorized to do so. Moreover, I understand that confidentiality also extends to all programmatic and organizational information acquired in the course of serving as volunteer, staff or board member, to include, but not be limited to a) materials and programs developed and used by Redmond - Sisters Hospice , b) personnel information, c) patient/family data, d) financial or operational data. I agree that the above material is the property of Redmond - Sisters Hospice. All research projects shall be approved by both the Chairman of the Board and the Executive Director to assure that the project is consistent with the goals and operating plans of the organization, and to assure that all research is in the best interest of our patients and families. Any research conducted shall take into consideration the needs of patients and families and shall always protect their well-being. Redmond - Sisters Hospice, through the Chairman of the Board and the Executive Director, shall approve the publications to which research or other papers are submitted. Redmond - Sisters Hospice shall be reasonable in considering above requests and approval shall not be unreasonably withheld. I understand that the Executive Director and his/her designee shall be the official spokesperson for the organization, and the Chairman of the Board shall be the official spokesperson for the Board of Directors. I will neither disclose any information or materials to any persons who are not employees of Redmond - Sisters Hospice, nor will I copy or remove the same from the premises of Redmond - Sisters Hospice, nor will I use the same for my personal benefit or for the benefit of any other person or corporation other than Redmond - Sisters Hospice. I further understand that divulging any information without authority may be grounds for appropriate action, including dismissal.

Signature____ Date___________________

Signature_________________________________Name (please print)________________________Date______________