



7112 Vedder Road  
Chilliwack, B.C. V2R 3T6  
Phone: (604) 795-4660  
Fax: (604) 795-2476

## CLIENT & PATIENT VOLUNTEER TRAINING APPLICATION CONFIDENTIAL

### **Personal Information:**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (year/month/day)

All volunteers are required to be fully vaccinated. I have been fully vaccinated for COVID-19? Yes ☐

Can we share your contact information with other Hospice Volunteers? Yes ☐ No ☐

I grant permission for photographs/videos, written evaluation comments, or interviews to be used for educational purposes and/or to promote the Programs and Services of the Chilliwack Hospice Society? Yes ☐ No ☐

### **Education/Special Training:**

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### **Work Experience during the past five years:**

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Do you have a car or access to transportation? Yes ☐ No ☐

Do you speak a language other than English? Yes ☐ No ☐

Language: \_\_\_\_\_ Speak \_\_\_\_\_ Read \_\_\_\_\_ Write \_\_\_\_\_

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**How did you hear about our Hospice Volunteer Programs and Services?**

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**Why do you want to be a Hospice Volunteer?**

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**What personal qualities (skills, knowledge and experiences) do you have that will help you in the work you will do as a hospice volunteer?**

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**Have you experienced the death of a loved one in the past 12 months?** Yes ☐ No ☐

If so, please explain:

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**What are your thoughts and feelings about death?**

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**Have you ever been with someone at the time of their death?**

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**When thinking of your own death, what words best describe death to you?**

I do not think about my own death ☐ Sorrowful ☐ Natural ☐ Frightening ☐ Painful ☐

Lonely ☐ Joyful ☐ Heavy ☐ Peaceful ☐ Dark ☐

**Other:**

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**REFERENCES: 3 are required** - 1 from your current or most recent employer/supervisor; and 2 people who are not immediate family and who have known you for at least three years.

Name	Contact Number	Relationship

### **Code of Ethics for Volunteers**

As a volunteer, I realize that I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume certain responsibilities and expect to account for what I do in terms of what is expected of me. I understand that any information which is disclosed to me while volunteering with the Chilliwack Hospice Society is confidential.

I interpret “volunteer” to mean that I have agreed to work without compensation in money. I understand that I will be required to complete a police record check, meet with the Palliative & Bereavement Services Manager and successfully complete the 35-hour volunteer training before being accepted as a Client and Patient Volunteer. It should be noted; however, that even after completion of the volunteer training, not everyone is accepted as a volunteer.

### **Declaration**

I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application I authorize enquiries to be made concerning my employment, character, and public records for the purpose of determining my suitability as a volunteer. I agree to respect the confidentiality of any client information I acquire in the course of my volunteer activities with the Chilliwack Hospice Society.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*For Office Use:*

Date Received: \_\_\_\_\_

Interview date/time: \_\_\_\_\_