Position Title: Staff and Office Support

General Statement of Duties: Under the direction of appropriate staff member and with the support from the Manager of Volunteer Services, performs daily data entry, handles correspondence and other word-processing assignments, provides clerical duties including filing and copying, and performs other general office duties as requested under the direction of Manager of Volunteer Services and appropriate staff member.

Functions:
1. Data entry as requested.
2. Prepares and processes correspondence and other word processing assignments using the appropriate available software.
3. Maintains filing systems accurately.
4. Provides other general office duties as needed.
5. Handles routine correspondence with donors, patients, and families.

Requirements:
1. Demonstrated knowledge of databases, spreadsheets, and word processing software, if applicable.
2. Attention to detail.
3. Ability to maintain accurate records and files.
4. Ability to work well with others.
5. Ability to maintain confidentiality about patients, families, donors and other sensitive aspects of the organization.
6. Willingness to accept supervision.
7. Motivation to work for the dying and bereaved according to the hospice concept and Coastal Hospice policies.
8. Successful completion of Coastal Hospice orientation.
9. If using automobile for Coastal Hospice duties, a valid driver’s license, and $100,000/$300,000 automobile liability insurance.

Signature: ______________________________________ Date: ______________________
Guidelines for Staff and Office Support Volunteers

Patient Support volunteers are asked to attend a three-hour course. If an applicant has documentation of attendance in a similar program elsewhere, that training will be reviewed and may be accepted with the approval of the Manager of Volunteer Services.

How to Apply
Call Volunteer Services at the Coastal Hospice office 410-543-2590 to make an appointment with the Manager of Volunteer Services. At the interview, the type of service, hours available and other matters related to volunteering will be discussed.

Coastal Hospice Offers
- Opportunities for meaningful community service
- Fellowship and fun at volunteer gatherings

Volunteers will be asked to
Refrain from the use of alcohol and tobacco while on assignment
Sign: Conflict of Interest, Confidentiality Agreement and Position Description
Complete a HIPAA post test
Consent to a background check
If needed provide your own transportation
Notify Volunteer Services of any change of availability or extended times of absence
Complete and return all record keeping forms promptly
Wear a name badge (provided by Coastal Hospice) when on assignment
If needed, provide your own transportation
Provide proof of current driver’s license and current auto insurance (if applicable)
Complete yearly updates and evaluation

Duties, Functions and Requirements of a Patient Support Volunteer are listed on the Patient Support Volunteer position description.

Assignments of Volunteers
All volunteer assignments are made through Volunteer Services. Patient Support Volunteers will be assigned according to their interest and availability.
VOLUNTEER APPLICATION

PERSONAL INFORMATION

Name:________________________________________________________________________
Address:________________________________________________________________________

Phone Number: (H) _______________ (W) _______________ (cell)_______________________
Email:________________________________________________________________________

We would like to recognize your birthday if you care to share the
date___________________________

Notify in case of emergency: Name________________________________________
Relationship___________
Address: ________________________________________Phone Number: _________________

Current Occupation: __________________________ Place of Employment____________________

Referred by: __________________________________________________________________

If you possess a license, certificate or registration as a result of specialized education or
training, please complete the following:

Title: __________________________ License or Registration No.: _____________ State: ______

Date Issued: __________________________ Date of Expiration: ______________________

Do you carry professional liability insurance?    Yes ☐    No ☐

Have you ever been convicted of a felony?      Yes ☐    No ☐

OTHER WORK EXPERIENCE (include paid and volunteer)

________________________________________________________________________

________________________________________________________________________

EDUCATION (include continuing education or special training)

________________________________________________________________________
SPECIAL SKILLS (foreign language, typing, hobbies, etc.)

What hours and days are you generally available?

The following information is needed to provide excess coverage over your personal insurance if you are using your vehicle while in the course of Coastal Hospice business:

   Driver’s License No.________________________ State____________

Attach a copy of your auto insurance certificate, which states the limitations of coverage. Updated certificates must be furnished as issued.

WORK PREFERENCE: Please indicate the type of volunteer work you would like to perform at Coastal Hospice:

REFERENCES: Please list three people we may contact.

I hereby authorize Coastal Hospice, Inc., to ascertain any and all information which may be pertinent to my volunteer duties. I release any individual from all liability for damages that may result to me on attempts of compliance or any attempts to comply with this authorization.

<table>
<thead>
<tr>
<th>Name</th>
<th>Mailing Address, Street, City, Zip</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Volunteer_________________________Date _______

Please complete and return to:
Judy Hunt-Harris, Manager of Volunteer Services
Coastal Hospice & Palliative Care
PO Box 1733 Salisbury, MD 21802
Initial Volunteer Survey

Name ________________________________________ Date ___________________

Address ____________________________________________________________________________

Home Phone ___________________________ Work Phone ____________________________

Cell Phone _______________________ E-mail Address _____________________

I would like the following phone number as my primary contact _________________

We would like to recognize your birthday if you care to share the date____________________

I am a Veteran ___Yes ___No

I am interested in the following (check all that apply)

___Clerical/Reception (choose any of the following locations)
___Coastal Hospice Offices (Salisbury)  ___Coastal Hospice at the Lake (Salisbury)
___Coastal Hospice at the Ocean (Berlin)

___Home Hospice Patient care (including facilities such as nursing homes, group homes)
___Assigned a patient for ongoing needs ___Prefer no children
___Assigned a patient for single visit/short term ___Prefer non-smoking
___Prefer no pets

___Coastal Hospice at the Lake (Salisbury) ___Patient Care
___Thrift Shop (Berlin)

___Transportation ___I will travel outside the county in which I live
___Deliveries ___I will travel outside the county in which I live

___Bereavement ___ phone calls ___ letters

___Mailings
___Office Assistance ___ computer ___ phones ___ filing

___Special Events (Memorial Services, parties)

___Fundraising ___Public Relations (Health Fairs)

___Hospitality (prepare refreshments) ___ Gardening

___Meal Preparation for Patients

___Other ____________________________________________________________

Please return survey with application. Thank you!