Please complete and return to:
Manager of Volunteer Services
Coastal Hospice & Palliative Care
PO Box 1733
Salisbury, MD 21802
410 -543-2590

VOLUNTEER APPLICATION

PERSONAL INFORMATION Date: ______________

Name: ____ Phone (H):______________________

Address: ____ Phone (C): ______________________

City, State, Zip:____ Phone (W): ______________________

Birthday (mm/dd/yyyy): ______________ Email: ____

Are you a veteran? ___Y ___N Preferred method of contact: ☐ H ☐ C ☐ W ☐ Email

Current Occupation:______________________ Place of Employment:_________________________________

Referred by: ___________________________________ Send your Volunteer Newsletter by __mail or __email?

OTHER WORK EXPERIENCE (include paid and volunteer)

____

____

EDUCATION (include continuing education or special training)

____

SPECIAL SKILLS (foreign language, music, gardening, cooking, crafting, transport patients/supplies)

____

Availability

	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Morning							
Afternoon							
Evening							

Preferences

❐ No Smoking
❐ No Pets
❐ No Children
❐ Will travel to other counties

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

❒ **Patient Care**
❒ **Fundraising/PR/Special Events**
❒ **Bereavement** (phone calls, letters, etc.)
❒ **Meal Preparation**
❒ **Clinician/CertifiedTherapist** (pet, massage, clinical)
❒ **Administrative/Clerical/Reception**
❒ **We Honor Veterans/Honor Salute**
❒ **Thrift Shop** (Berlin)
❒ **Gardening/Maintenance**
❒ **Student/Intern**

REFERENCES: Please list three people that you have worked/volunteered with.

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.

Name *Mailing Address, Street, City, Zip* *Email address/Phone #*

1. ____

2. ____

3. ____

Notify in case of emergency:

Name______________________________ Relationship________________________

Emergency contact phone number__________________________

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 ❒

Coastal Hospice underwriters require confirmation of your personal automobile insurance. Please attach a copy of your driver's license and declarations page from your automobile insurance policy, which states the limitations of coverage.

______________________________ ______________

Signature of Volunteer **Date**