
# VOLUNTEER APPLICATION FORM

Date: _____

Name _____ Date of Birth _____/_____/_____

Cell Phone (  )_____ E-mail _____

Address _____
Street/Apt # City State Zip Code

Education/ Special Training/Special Skills:_____

_____

Work Experience:

_____

_____

OSU affiliated and how?_____ Veteran?_____

What is your availability for volunteer service: _____

What qualities (skills, talents, knowledge, and experiences) do you feel you can incorporate into your volunteer position?_____

_____

**In case of emergency contact: _____ Phone:(  )_____**

**Address: _____**
**Street/Apt # City State Zip Code**

Has someone close to you died within the past year? ____ Yes ____ No

If yes, please explain: _____

_____

**Please mark your areas of interest for volunteering below**

| Patient/Family Visit | Bereavement | Administrative Services |
|---|---|---|
| ___ Patient Home | ___ Caller | ___ Clerical |
| ___ Life Review | ___ Home visits | ___ Fundraising/Special Events |
| ___ Pet Therapy | ___ Office/Clerical | ___ Answering Telephone |
| ___Baked Goods | ___ Memorial Service Committee | ___ Patient Documentation |
| ___ Birthday delivery | | |
| ___ Holiday Creations | | |
| ___ Veterans Recognition | | |

Please give any other information you feel pertinent to your application: _____
_____
_____
_____

**BELOW FOR PATIENT SUPPORT VOLUNTEER INTEREST:**

Would you be willing to work with an AIDS or HIV+ patient? □ Yes □ No

Would you be willing to work in a home where the patient and/or family smoke? □ Yes □ No

Do you smoke? □ Yes □ No

Are you willing to work with a patient/family that has a history of alcoholism? □ Yes □ No

Will you attend our in-services and additional educational workshops? □ Yes □ No

Do you have any allergies? (Please explain) _____
_____

How long are you willing to commit with our program? _____

DEATH AND DYING

Do you fear death?_____

_____

Do you fear the death of a loved one more or less than your own? ☐ More ☐ Less

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

_____

Have you ever provided "nursing" care to anyone? ☐ Yes ☐ No

If yes, please explain _____

_____

How do you feel about your own death?

☐ I do not think about my own death ☐ sorrowful ☐ natural ☐ frightening ☐ dark

☐ lonely ☐ joyful ☐ peaceful ☐ heavy ☐ other _____

**Two Personal References (excluding family members)**
Please provide a complete mailing address or e-mail address,
as references are verified. **PLEASE PRINT**

Name _____ Relationship _____

Address _____
Street/Apt# City State Zip Code

Phone ( ) _____ E-Mail Address _____

Name _____ Relationship _____

Address _____
Street/Apt# City State Zip Code

Phone ( ) _____ E-Mail Address _____

**THE ABOVE INFORMATION IS ACCURATE & CORRECT TO THE BEST OF MY KNOWLEDGE.**

**Opportunities for volunteers are provided without regard to race, color, sex, age, religion, national origin, marital status, sexual preference/orientation, qualified disability and veteran status.**