VOLUNTEER APPLICATION FORM

NAME ____
(Last) (First) (Middle)

ADDRESS ____
(Street) (City) (Zip)

PHONE ____
(Home) (Work, if OK to receive calls) (Cell)

EMAIL ADDRESS ______________________________

DATE OF BIRTH ____________ SOCIAL SECURITY NUMBER ____________

Education Completed: High School _____ College _____ Graduate _____ Nurses' Training _____ Tech. School _____

Special Skills or Training ____

____

WORK EXPERIENCE

Current Job Title or Position ____________________ Kind of Business ____________

Duties ____

Name and Ph. Number of Supervisor ______________________________

VOLUNTEER EXPERIENCE

Organization(s) ____

What is your reason for volunteering to work with dying patients and their families? ____________

____

What qualifications would you bring to your work with Hospice? (Past volunteer work, professional training, experience with terminally ill, etc.)

____

Describe your view / concept of death and dying. ______________________________

____

Describe how you might work with patients / families whose personal beliefs and lifestyles may be different from your own.

____

____

Have you ever experienced the death of a close relative or friend? __________ If so, when? ____________

How did the experience affect you? ______________________________

Have you recently experienced any other major loss such as a divorce, illness, or move? ____________________

How much time are you able to volunteer to Hospice each week? ____________________

Are there days or times you are NOT available to volunteer? ____________________

Do you have an insured car available for your use at most times? ____________________

Which of the following duties would you be willing to do for the Hospice program or any assigned patient / family? (Check all that apply.)

_____ Home visits _____ Phone calling _____ Sending cards _____ Making treats

_____ Running errands _____ Sitting with patients _____ Fund-raising _____ Clerical work

_____ Computer work _____ Public relations

Is there anything that would make you feel uncomfortable or that you would not be willing to do? ____________________

____

Are there any physical limitations that would keep you from performing certain duties? ____________________

____

Are you willing to serve in Hospice for at least one year? ____________________

Are you prepared to travel to Beardstown to attend the volunteer monthly training meetings? ____________________
(10 per year, of which you will need to attend a minimum of 8.)

PERSONAL REFERENCES

Please provide a complete address and phone number for TWO references, excluding family members.

1) NAME ____________________ PHONE ____________________

ADDRESS ____________________

2) NAME ____________________ PHONE ____________________

ADDRESS ____________________

FOR OFFICE USE ONLY

Application evaluation: ____________________

____

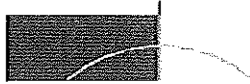
Interview evaluation: ____________________

____

____

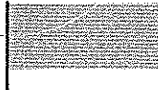
Evaluated by ____________________ Date ____________________

(Rev. March 2005)



Cass County Health Department

Protecting...Providing...Promoting...
since 1981



331 S. MAIN, VIRGINIA, IL 62691
(217) 452-3057

Mandatory Background Check Form
This information is confidential and will be stored in a confidential manner.

Name ____
(Last) **(First)** **(Middle)** **(Maiden)**

Date of Birth (mm/dd/yyyy) ____________________ **Gender:** ☐ **Male** ☐ **Female**

Ethnicity:

_____ Black (not Hispanic) _____ Asian / Pacific Islander _____ Indian / Alaskan Native _____ White (including Hispanic)

The State of Illinois mandates that any health care agency shall not knowingly hire an individual after January 1, 1996 in a position with duties involving direct care for patients if that person has been convicted of committing or attempting to commit one or more of the following offenses: murder, homicide, manslaughter, concealment of homicidal death, kidnapping, child abduction, unlawful restraint or forcible detention, assault, battery, infliction of great bodily harm, sexual assault, sexual abuse, abuse or gross neglect of long-term care facility resident, criminal neglect of elderly or disabled person, theft, financial exploitation of elderly or disabled person, robbery or burglary, criminal trespass, arson, unlawful use of weapons, or aggravated discharge of a firearm, manufacture/delivery/trafficking of cannabis or controlled substances.

I understand that the offer of employment is contingent upon the successful completion of a criminal background investigation. Should the investigation produce information that does not meet the Federal, State, or County guidelines, my employment with the Cass County Health Department (CCHD) will be terminated immediately.

I hereby authorize local and/or state law enforcement to furnish CCHD information related to my criminal history. I understand that a background check may be repeated at any time. I hereby release CCHD and all its agents and employees, the law enforcement agency and their employees furnishing information from all liability resulting from the furnishing of this information to CCHD. I certify that the statements made by me on this form are true, complete and correct to the best of my knowledge and belief and are made in good faith. I understand that any false statements made herein will terminate my employment with the CCHD.

______________________________________ ____________________
Signature **Date**