

# Application for Volunteer Service Program



**99 Sunnyside Blvd  
Woodbury, NY 11797**

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, martial or veteran status, or any other legally protected status.

Please complete each item on this application and return it to the Volunteer Office. Thank you for your interest in volunteering at Hospice Care Network.

Date of Application: \_\_\_\_\_

Position(s) Applied for:	
<input type="checkbox"/> Administrative Volunteer	<input type="checkbox"/> Licensed Massage Therapy Volunteer
<input type="checkbox"/> Patient Care Volunteer	<input type="checkbox"/> Certified Pet Therapy Volunteer
<input type="checkbox"/> Hairstylist Volunteer	<input type="checkbox"/> Special Events Volunteer

How did you learn about us? Please Specify:
<input type="checkbox"/> Advertisement: _____
<input type="checkbox"/> Volunteer: _____
<input type="checkbox"/> Relative/Friend: _____
<input type="checkbox"/> Inquiry (with whom did you speak?): _____
<input type="checkbox"/> Other: _____

Last Name		First Name		Middle Initial	
Address	Number	Street	City	State	ZIP Code
Home Telephone Number		Work Telephone Number		Cell Phone Number	
( ) -		( ) -		( ) -	
Email Address:					

<b>In Case of Emergency, Notify:</b>	
Name	
Telephone Number	Cell phone Number
( ) -	( ) -
Relationship	

Have you ever filed a volunteer application with Hospice Care Network before? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever volunteered with Hospice Care Network before? If yes, when?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently employed or volunteering?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you legally able to volunteer in this country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a felony? If so, please indicate details below. (A felony conviction will not necessarily bar an applicant from volunteering).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Volunteers with Hospice Care Network <i>may</i> be asked to travel for more than 30 minutes. Will you be able to travel <i>if needed</i> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>School</b>	<b>Education Name of School</b>	<b>Course of Study</b>
<b>High School</b>		
<b>Undergraduate College</b>		
<b>Graduate/Professional</b>		
<b>Other (please specify)</b>		

<b>Please List Your Professional License Number and Registration Expiration Date</b>	
Number:	Exp. Date:

<b>Pertinent Work Experience</b>	
Employer/Organization	
Work Performed	
Starting Date	Final Date

<b>Prior Volunteer Experience (Please list volunteer positions you have held)</b>	
Organization (s)	
Volunteer Responsibilities (please list)	

Describe any specialized training, apprenticeship, skills and extra-curricular activities, office held, etc.


Do you speak/understand/read/write any foreign language? Please fill in:

Speak:	Understand:
Read:	Write:

Describe any computer skills and/or work-related training or volunteer-related training:


**Personal/Professional References** *Do not include family members.*

Name	Phone Number	Address
1.	(     ) -	
2.	(     ) -	

**Volunteer Applicant’s Statement**

I certify that answers given herein are true and complete. I authorize investigation of all statements contained in this application for Volunteer Service Program as may be necessary in arriving at a volunteer opportunity decision.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any volunteer relationship with this organization is of a non-paid “at will” volunteer relationship.

In the event of being accepted into volunteer service, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the Hospice Care Network.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**



TO: All Volunteers  
FROM: Sommer Allen, Manager of Volunteer Services  
RE: Documentation Requirements for volunteering

The following documentation is required of applicants in order for Hospice Care Network to be in compliance with all regulations. These requirements are to be completed **prior** to the beginning of orientation.

1. Initial Health Assessment form (to be completed by your physician) which will include the following:

- Proof that you must be free of clinical signs and symptoms of tuberculosis. This can be obtained by one of the following 3 options:
  - Option 1: A 2-step process for TB screening.** Please have your physician give and read your tuberculosis test (TST) prior to orientation and *write the results of TST on the form in millimeters*. During orientation a 2<sup>nd</sup> TST will be given.
  - Option 2:** One of the **approved whole blood interferon gamma release assays tests** listed below:
    - QAuantiFERON-TB Gold, 2005
    - QuantiFERON-TB Gold In-Tube 2007
    - TSpot, TB, 2008
  - Option 3:** If you are **unable to receive a TST due to a past positive reaction to a TST**, please have a chest x-ray and have your physician write a note that your lungs are clear of tuberculosis.
- Immunizations:
  - If born before 1/1/57** Lab Reports must be attached showing immunity (positive) to Rubella and Varicella (**IGG**).
  - OR**
  - If born after 1/1/57** Lab Reports must be attached showing immunity (positive) to MMR - Measles (Rubeola), Mumps, Rubella and Varicella (**IGG**).
  - If you are found to be non-immune in any of the above lab reports within this section, you must obtain a booster shot and submit proof of immunization(s) (booster shot) given.

2. Proof of I9 Documents (may include original passport or current driver's license and original social security card.)
3. Applicant Information Verification and Background Check Authorization (*to be completed during training*)
4. Cosmetology License (if applying for the haircutting program)
5. Massage Therapy License and Registration (if applying for massage therapy program)

*If you have any questions, please call the Volunteer Office Monday through Friday, 8:30-4:30 at 516-224-6416. If you live in Queens, you may call 718-746-6142, extension 4404.*

*If you would like to fax your application, please fax to (516) 832-7160 with a cover sheet to the volunteer department. For mailing, please mail to the volunteer dept. at HCN, 99 Sunnyside Blvd., Woodbury, NY 11797.*

**HOSPICE CARE NETWORK**  
**INITIAL HEALTH ASSESSMENT FORM**

[ ] **Employee** [ ] **Volunteer** [ ] **Intern**

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

TST (Tuberculin Skin Test) Results: Positive \_\_\_\_\_ mm Negative \_\_\_\_\_ mm

Date Administered: \_\_\_\_\_ By: \_\_\_\_\_

Date Read: \_\_\_\_\_ By: \_\_\_\_\_

If TST positive, Chest X-Ray will be required – *attach report*

If using one of the IGRAs (Interferon-Gamma Release Assays) – *lab report must be attached*

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Immunizations:

**If born before 1/1/57** Lab Reports must be attached showing immunity (positive) to Rubella and Varicella (**IGG**).

**OR**

**If born after 1/1/57** Lab Reports must be attached showing immunity (positive) to MMR - Measles (Rubeola), Mumps, Rubella and Varicella (**IGG**).

If named person is found to be non-immune in any of the above lab reports within this section, proof of immunization(s) given after lab reports, will be required.

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The employee/volunteer/intern is able to perform the respective tasks, which may include but not limited to:

Traveling, stair climbing, lightweight carrying, assisting caregiver in providing services to a patient and light household tasks.

*The above named person has been examined by me and may perform all tasks as stated above:*  
**yes  or no . IF no, please state limitations:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Signature & Stamp

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

HCN Medical Director's Signature

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