Trinity Hospice
VOLUNTEER APPLICATION

TRINITY HOSPITALS

Date:_____

Name:_____ Phone:_____
Last First

Address:_____ Birthdate:_____
Street City State Zip Code

Employer, if applicable:_____ Work Phone:_____

May we contact you at work? ☐ Yes ☐ No

Emergency Contact Person:_____ Phone:_____
Name Relationship

Church Affiliation:_____ Parish:_____

Work skills, interests, hobbies:_____

_____

Previous volunteer experience:_____

_____

Organizations or clubs you belong to:_____

_____

Describe any health conditions which may affect the type of work you do:_____

_____

References: (non-relative)
1)_____ Phone:_____
2)_____ Phone:_____

Hours Available to Volunteer:

	A.M.	P.M.	Evening
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Site preferred:_____ ☐ Hospital

_____ ☐ Trinity Homes

_____ ☐ Patient Home

Your e-mail address:_____

Comments:_____

_____

_____

_____

Volunteer's Signature:_____ Date:_____