VOLUNTEER APPLICATION
NAME AND ADDRESS

Name _____
Last First MI

Street address _____
City State Zip

Preferred Contact:
Home phone _____ ☐ Email address _____
Work phone _____ ☐
Cell phone _____ ☐ Are you over the age of 18? _____

EDUCATION/SPECIAL TRAINING

☐ High school ☐ College ☐ Graduate School ☐ Specialized training _____

PREVIOUS VOLUNTEER EXPERIENCE

Name of Organization	Type of Work	Date

EMPLOYMENT
Are you currently employed? ☐ Yes ☐ Full time ☐ Part time ☐ No

Name of employer _____

AREAS OF INTEREST
You may check more than one.

☐ Patient/family homes ☐ Patient/family facilities ☐ HopeHealth Hulitar Hospice Center

☐ Pediatric ☐ Office ☐ Philanthropy ☐ Bereavement ☐ Events ☐ Camp BraveHeart

☐ Reiki* ☐ Pet Therapy * ☐ Veterans

**These disciplines must be licensed or certified*

What languages do you read, write, speak? _____

Do you have access to transportation? ☐ Yes ☐ No

Areas or towns in which you wish to volunteer: _____

What days and times are you available to volunteer?

_____

_____

How did you hear about HopeHealth? _____

REFERENCES Please give two personal references who are NOT family members.

Name _____ Phone _____ E-mail _____

Address _____

Name _____ Phone _____ E-mail: _____

Address _____

DECLARATION: I hereby certify that the statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application I authorize inquiries to be made concerning my suitability as a volunteer.

_____ _____

Volunteer Signature Date

Return application to:
Volunteer Department
HopeHealth
1085 North Main Street
Providence, RI 02904