

**CASTLEGAR HOSPICE SOCIETY
VOLUNTEER APPLICATION**

NAME _____ DATE _____

BIRTHDAY _____ AGE _____ PHONE(H) _____

PHONE (W) _____ STREET ADDRESS _____

MAILING ADDRESS _____ CITY/CODE _____

We require one piece of photo identification (e.g.) BC Driver's License: _____

Areas of Interest: Direct patient contact Bereavement Office
 Fundraising Public Speaking Other

Day/Time Available: _____
 # of hours per week days of the week am/pm weekends

Current Employer _____

Job responsibilities _____

List physical limitations/considerations _____

Emergency Notification _____

Name		Relationship	
Address	City/Prov/Code	Address	Phone

REFERENCES:

Name _____ Relationship _____

Address _____ City/Prov/Code _____

Phone _____ Occupation _____

Name _____ Relationship _____

Address _____ City/Prov/Code _____

Phone _____ Occupation _____

SIGNATURE _____ **DATE:** _____