Gulfside Healthcare Services

Hospice | Palliative Care | Home Health

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: ___

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: _____ Email: _____

Date of Birth: _____ Under 18: ____

Background Screening Information: (18 and older only)

Country/Citizenship: _____ SSN: _____

Driver's License: _____ State Issued: _____

Sex: _____ Race: _____ Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Place of Birth: _____ Maiden Name: _____

Florida Resident: Permanent: _____ Seasonal: _____

Dates in Florida if Seasonal: _____

Preferred method of communication: Phone: _____ Email: _____ Mail: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Do you have previous volunteer experience with Gulfside? Yes ____ No ____

Do you currently volunteer for another Hospice? Yes _____ No _____

Employment Status: Full time: _____ Part time: _____ Retired: _____ Self Employed: ___ Not Employed: ___

Education: Some High School: _____ High School Graduate: _____

Some College: _____ College or University Graduate: ___

Do you know a foreign language? Yes: _____ No: _____ If yes, which language? _____

Have you ever served in the Armed Forces? Yes: _____ No: _____ Branch: _____

Are you currently in the Armed Forces? Yes: _____ No: _____ Branch: _____ Reserves? _____

All volunteers working in a patient care related area must provide proof of annual TB Test and annual Flu Vaccine. If annual Flu Vaccine is declined, volunteer must wear mask when working in patient related areas.

Date of last TB test: _____ *Date of Flu Vaccine:* _____

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Do you have physical restrictions that might limit your volunteer placement in specific areas within Gulfside?

Yes: ___ No: ___

Please specify: _____

What areas of Volunteering interest you? (Mark all that apply)

_____*Office Support*

_____*Administrative/Data Entry*

_____*Reception/Greeter*

_____*Crafts*

_____*Pet Peace of Mind*

_____*Veteran's Program*

_____*Gift of Presence*

_____*Courier*

_____*Spiritual Care Volunteer*

_____*Community Outreach and Events*

_____*Patient Care/Companionship/Respite*

_____*Patient Care - In-Patient Centers/Facilities*

_____*Kitchen*

_____*Bereavement Department*

AGREEMENT

I certify that the answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this Volunteer Application as deemed necessary for volunteer participation. I understand that this application is not and is not intended to be an offer of employment. In consideration of being a Gulfside Hospice volunteer, I do hereby assume the risk of injury and all medical expenses incurred from any injury resulting from my volunteer participation. I understand, acknowledge and agree I am not covered by Workers' Compensation Insurance or benefits provided there under and I do hereby release, discharge, and hold harmless Gulfside Hospice, its agents, representatives, and employees from all claims whatsoever, known or unknown, for damages or injuries to myself.

I attest that the information above is true and factual and that it was completed in its entirety, by me, for the purpose of background screening clearance to Volunteer with Gulfside Hospice.

Applicant Signature: _____ Date: _____

Parent/Guardian Signature: (If Minor) _____ Date: _____