

Office Use Only:

- Application received: _____
- Police form received: _____
- Induction/Screening: _____
- Interview: _____
- Reference Check: _____
- Screening Result: _____

VOLUNTEER APPLICATION FORM
General Volunteers

(please print clearly)

Full Name:			
Prefer to be known as:			Title: Mr/Mrs/Miss/Ms
Address:			Postcode:
Telephone numbers:	Home:	Work:	Mobile:
Email address: <small>(please print clearly)</small>			D.O.B: <small>(for birthday acknowledgement only – year is optional)</small>
Occupation:			
Emergency Contact: <small>(name, relationship, phone)</small>	Phone:		
Please specify your ethnic origin <i>(please circle)</i>:			
European Asian Maori Pasifika Middle Eastern/Latin American/African			
Other <i>(please state)</i> :			
Do you speak any other language, apart from English (please state):			

Please provide as much information as you can on the following questions:

What personal qualities make you suitable for Hospice work?
If you have previous experience in volunteer work, please describe where and what you did:
Are there other interests and skills you could bring to the Hospice?
Why do you want to work for Hospice Wairarapa

Have you experienced personal bereavement, and when did this happen?

What type of work would you like to do for the Hospice? *(Please tick all appropriate)*

Patient Contact Services		Non-Patient Contact
<input type="checkbox"/> Baking/Meals	<input type="checkbox"/> Gardening	<input type="checkbox"/> Administration Support
<input type="checkbox"/> Bereavement Support	<input type="checkbox"/> Hairdressing/Beauty Care	<input type="checkbox"/> Flowers/Gardening
<input type="checkbox"/> Biography Service	<input type="checkbox"/> Patient/Family Support	<input type="checkbox"/> Fundraising
<input type="checkbox"/> Companion/Visitor	<input type="checkbox"/> Patient Transport/Shopping	<input type="checkbox"/> House Volunteer
<input type="checkbox"/> Day Programmes	<input type="checkbox"/> Spiritual Care	
<input type="checkbox"/> Other (please specify)		

Do you have any medical conditions that may affect your ability to carry out Voluntary Hospice Duties:

Please indicate a day/time commitment that best suits you to Volunteer:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
am/pm	am/pm	am/pm	am/pm	am/pm	am/pm	am/pm

Please indicate number of hours per week/month that you can volunteer.

References:
Could you please supply the name and contact details of one personal referee who you know will be happy to support your application to become a Volunteer *(note that your referee should not be a close relative)*

Name	Relationship	Address	Phone No

Do you have any criminal convictions?

Yes No

If yes, what was the offence:

By signing this form, you also agree to notify Hospice Wairarapa if you are ever convicted of a criminal offence

If placed in a volunteer position I agree to:

- attend the Volunteer Training Programme
- work within Hospice Wairarapa protocols, as outlined during induction and training
- consent to disclosure of information from the Police Vetting Service

Signed: _____ **Date:** ___/___/___

Please send your completed Volunteer Application form **by post** to:
Manager, Volunteer Services, Hospice Wairarapa Community Trust, 59 Renall Street, Masterton 5810
Or email: chris.wills@hospicewairarapa.co.nz **Contact numbers:** 06 378 8888 or (DDI) 06 949 7503

Hospice Wairarapa will use all methods available to protect our patients, their families, our employees, volunteers and the reputation of our organisation from disrepute, and has been accepted as an approved organisation to the vetting service of the New Zealand Police. This allows organisations, whose core function is the provision of care to other people, to check the criminal history of volunteer appointees. Therefore all applicants are requested to sign and return a consent for disclosure form. All information received from the New Zealand Police is stored confidentially on appointment or, on non-appointment, confidentially destroyed.

Volunteer Confidentiality Agreement

Patients and families involved with Hospice Wairarapa are accorded confidentiality. As a Volunteer with this organisation, I agree to respect and maintain this trust.

I AGREE to my name and phone number being used within the Hospice. The personal information contained in this form will be held by and remain confidential to the management team of Hospice Wairarapa. Under the Privacy Act 1993, I have the right (with certain exceptions) to request access to, and correction of, any of my personal information held by the Hospice.

I DECLARE that all the information provided by me in support of my application is correct. I acknowledge that if I have provided incorrect or misleading information or have omitted information of significance, I may be disqualified from becoming a Volunteer or, if appointed, be liable to be dismissed.

Signed: _____ Date: ____ / ____ / ____

*Thank you for volunteering for Hospice work. We trust that you will find your Volunteering rewarding.
Please do not hesitate to contact the Manager of Volunteer Services, Chris Wills
Phone 06 378 8888 or DDI 06 929 7503 if you have any queries.*