Gulfside Hospice
Lic. 1989

Please complete each page and return it to Gulfside Hospice at one of the addresses listed on the signature page. We appreciate your interest in volunteering with Gulfside Hospice. **A clean background check without a misdemeanor or felony is necessary to become a volunteer.** Applicants under age 18 will NOT be subject to a background check.

Personal Information:

Date:

First name: Last name:

Street Address:

City: State: Zip Code:

County: Email address:

Home Phone: Cell Phone:

Florida Resident: ☐ Permanent ☐ Seasonal Dates in Florida if Seasonal:

Preferred method of communication: ☐ Email ☐ Mail ☐ Phone

Under Age 18? ☐

Emergency Contact Information:

Name:

Phone: Relationship:

Volunteer History:

Are you currently volunteering at another hospice? ☐ Yes ☐ No

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

Why are you interested in volunteering with Gulfside Hospice?

Have you experienced any deaths in your family, or someone close you?

Employment Status:

☐ Employee Full Time ☐ Employed Part Time ☐ Self Employed ☐ Retired ☐ Not employed

Education Status:

☐ Some or no High School ☐ High School Graduate ☐ College Degree ☐ Some College/Certification/Technical School

☐ Postgraduate Work Field of Study:

Skills:

Do you know a foreign language? ☐ Yes ☐ No

If yes, please specify language(s):

Please list special skills and/or hobbies you have:

What organizations do you belong to (if applicable)?

Armed Forces or Veterans Status:

Have you ever served in the Armed Forces? ☐ Yes ☐ No

Are you currently in the Armed Forces? ☐ Yes/Full Time ☐ Yes/Reserves ☐ No

If yes, please specify branch.

Physical Health:

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 your last TB test: Date of your last flu vaccine:

Do you have physical restrictions that might limit your volunteer placement in specific areas within Gulfside? ☐ Yes ☐ No

If yes, please specify:

What areas of volunteer opportunities interest you?

- ☐ Office Support
- ☐ Data Entry
- ☐ Reception/Greeter
- ☐ Crafts
- ☐ Bereavement Department
- ☐ Grief Support
- ☐ Veteran's Program
- ☐ Gift of Presence
- ☐ Courier
- ☐ Spiritual Care Volunteer
- ☐ Patient Care/Companionship/Respite
- ☐ Patient Care - In-Patient Centers/Facilities
- ☐ Zephyrhills Care Center Kitchen
- ☐ Grocery Shopping/Errand Running
- ☐ Community Awareness/Special Events/Health Fairs
- ☐ Pet Peace of Mind

Thrift Shoppes:

☐ New Port Richey ☐ Hudson ☐ Lutz/Land O Lakes ☐ Dade City ☐ Zephyrhills

☐ Other Please explain: _____

AGREEMENT

I certify that 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 any and all claims whatsoever, known or unknown, for damages or injuries to myself.

_____

Applicant Print Name

Applicant Signature & Date

_____

Parent/Guardian Print Name

Parent/Guardian Signature & Date

Return Application to the address listed below:

Gulfside Hospice
Attn: Volunteer Department
2061 Collier Parkway
Land O' Lakes, FL 34639

or
volunteerrecruiter@gulfside.org

Gulfside Hospice
Lic. 1989

Volunteer Profile

Information for Background Screening Registration

First Name:

Middle Name:

Last Name:

Maiden Name:

Suffix:

Street Address:

City: State: Zip Code:

Phone Number: Email Address:

SSN: Date of Birth:

Country/Citizenship: Place of Birth:

Driver's License #: State Issued:

Sex: Race:

Height: Weight:

Eye Color: Hair Color:

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.

Signature: Date:

Gulfside Healthcare Services
Hospice | Palliative Care | Home Health

MODEL RELEASE

I hereby give Gulfside Healthcare Services or its agents, the absolute right and permission to copyright and/or publish, or use video, photographic portraits or pictures of me or statements made by me, made through any media at its studios or elsewhere, for art, advertising, trade or any other lawful purpose whatsoever.

I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied. I hereby release, discharge and agree to save Gulfside Healthcare Services and its agents from any liability or payment for use of my image or statements.

Model Name _____

Address _____

Phone _____

Signature _____ Date _____

Parent/Guardian Signature (required if a minor) _____

Date _____

Witness _____ Date _____