



## Volunteer Application

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Mobile: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

May we call you at work? ☐ Yes ☐ No

How did you find out about our hospice volunteer program? ☐ Legacy Employee

☐ Newspaper ☐ Hospice Volunteer ☐ Hospice Patient ☐ Other: \_\_\_\_\_

What made you decide to become a hospice volunteer? \_\_\_\_\_

Please indicate the services you would be most interested in providing as a hospice volunteer:

- ☐ Organization Support - Clerical help in office (filing, phone calls, mailings, etc)
- ☐ Patient & Family Care - Direct work with patients and families
- ☐ Running errands for patient and families
- ☐ Perform yard work that patients are no longer able to perform
- ☐ Angel Program – Provide emotional support and companionship to patients and their families in the last 24 to 48 hours of their life
- ☐ Transitions Program – Provide assistance, companionship, and other complimentary services to patients with a life expectancy of less than 18 months
- ☐ Bereavement support with families
- ☐ Teen Program – Students are actively involved in life review projects, arts & crafts, and our memorial services
- ☐ Other (please specify): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please fax your completed application to (434) 970-7773 or  
email to [sallieross@legacy-hospice.com](mailto:sallieross@legacy-hospice.com)

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