Created: 07/20/1995 Revised: 03/31/1999, 10/29/2000, 09/28/2004, 19/19/2005, 06/2009, 02/2014, 06/2014, 07/2014, 10/2016, 04/2019, 2/25/21

AVITA
HOME HEALTH
& HOSPICE

VOLUNTEER APPLICATION

Name: _____

Address: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____

Emergency Contact Name: _____ Phone #: _____

Have you been a resident of Ohio for the last 5 years? No __ Yes __

Have you ever been convicted of a felony? No __ Yes __

If yes, please explain: _____

Have you ever been accused or convicted of sexual abuse or molestation? No__ Yes __

If yes, please provide dates and details: _____

Military

Branch: _____ Years: _____ Title: _____

Employment (if applicable)

Current Occupation: _____ Years: _____ Title: _____

Education: High School __ Some College __ Associate Degree __ Bachelor's Degree __

Master's Degree __ Other: _____

Field of Study: _____

Certifications: _____

Volunteer Experience (Please provide name of organization, description of work and dates)

1. _____
2. _____
3. _____
4. _____

Special Skills and/or Hobbies

_____

_____

_____

How did you hear about Avita Home Health & Hospice?

Briefly describe why you would like to volunteer at Avita Home Health & Hospice.

I am interested in the following Volunteer positions:

Patient/Family Care

__ Companion
__ Respite
__ Vigil
__ Veteran Companion

Bereavement Support

__ Companion
__ Telephone Contact
__ Follow-Up Visits
__ Assist at Memorial

Administrative Support

__ Mailings
__ Data Entry
__ Telephone Calling
__ Filing

Specialized Volunteer

__ Pet Therapy
__ Music Therapy
__ Art Therapy
__ Chaplain Services

Special Projects

__ Crafts
__ Baking
__ Holiday Cards
__ Gardening/Avita Grounds

Marketing/Fundraising

__ Fundraising
__ Marketing Event Support
__ Funnel Cake Stand Worker
__

Do you have functional limitations which would need to be considered when making a patient assignment (i.e. allergies to animals, etc.)?

Signature: _____ Date: _____

Please Mail Application to:

Avita Home Health & Hospice
Attn: Volunteer Services
1220 N Market Street
Galion, OH 44833

or Fax Application to:

(419)468-9211
Attn: Volunteer Services

Office Use Only:

Interview Date: _____ Training Dates Completed: _____

VOLUNTEER HEALTH HISTORY RECORD

Please complete this questionnaire to better acquaint your physician (in case of an emergency) with your medical history. It will be filed as a part of your permanent confidential record.

NAME _____ DATE OF BIRTH _____

VOLUNTEER: Have you had any of the following? Please check Yes or No.

	YES	NO		YES	NO
Operation			Mental Disease		
Fracture			Asthma/Lung Condition		
Head Injury			Sinus Trouble		
Back Injury			Hernia		
Other Injury			Stomach Trouble		
Chronic Back Pain			Jaundice		
Heart Trouble			Rheumatoid Arthritis		
Tuberculosis			Hepatitis		
Chronic Skin Disease			Diabetes		
Fainting Spells			Measles		
Epilepsy			Mumps		
			Chicken Pox		

If yes, please explain briefly:

_____

_____

Have you received any of the following immunizations? If yes, give a year as close as possible.

	YES	NO	YEAR		YES	NO	YEAR
Mantoux Skin Test				Polio			
Tetanus				Diphtheria			
Influenza				Typhoid			
Measles				Mumps			

I have completed the above and declare that I have had no injury, illness, or ailment other than as specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

_____

Signature of Volunteer **Date**

Revised 6/2019