



Quesnel & District Hospice Palliative Care Association

BOX 4537, QUESNEL, BC, V2J 3J8 PH: 250-985-5816 FAX: 250-992-5216
Email: info@QDHPCA.org

Palliative Care Volunteer Application

Application Date: _____

Name: _____

Address: _____

Phone number: (Home) _____

(Cell) _____

(Work) _____

Email: _____

Date of Birth: _____

Do you have a valid license to drive? Yes No

Do you have access to a vehicle? Yes No

Language(s) spoken: _____

Please check all areas of interest to you:

Fundraising

Individual and/or family support of the dying:

GRB Hospital

Dunrovin Park Lodge

Quesnel Hospice

Maple House

Community

Bereavement support

Individual

Family

Other: _____

How did you hear about our volunteer program?

- Social Media QDHPCA Website Internet Friends/Family
 Other _____

Can you attend, at minimum, six volunteer education/support meetings a year? Yes No

Do you have any church or spiritual affiliation? _____

How many hours a week are you available? _____

Do you agree to work under the Volunteer Coordinator? Yes No

What time of day do you prefer? Mornings Afternoons Evenings

Unavailable days: _____

Why do you want to become a Palliative Care Volunteer? What skills (work, education, volunteering, experiences, etc) do you feel will assist you in being a client care volunteer?

What does helpfulness mean to you? _____

What strengths and limitations do you feel that you have with being a Palliative Care Volunteer?

We would like to get to know you better. Tell us about yourself, such as life history, hobbies and interests.

Please tell us about any experiences with death you may have had

In the past two years, have you had someone close to you die or have you experienced major loss? If so, please explain.

If someone was describing an experience very much like your own, how would you react?

Are there any type of situations, persons, or family that might be difficult for you to work with?

Criminal Records Check

In order to become a direct care Palliative Volunteer, a Criminal Records check must be performed. Have you completed one for this application? Yes No

References

We require two written letters of reference. Please provide the addresses, phone numbers and email addresses of your references

Name: _____

Address: _____

Phone number: _____

Email: _____

Name: _____

Address: _____

Phone number: _____

Email: _____

I understand that my name and/or photograph may be used for Association purposes. I will support the goals and policies of the Quesnel & District Palliative Hospice Care Association.

Signature: _____

Date: _____

Please return application to:

Email: info@QDHPCA.org

Mailing Address: QDHPCA
Box 4537
Quesnel, BC
V2J 3J8