



Hospice of Baton Rouge

Laura Savage
Volunteer Coordinator
9063 Siegen Lane, Suite A
Baton Rouge, LA 70810
(225)767-4673
(225)769-8113 fax
LSavage@hospicebr.org
www.hospicebr.org

VOLUNTEER APPLICATION

Name of Applicant _____ Date _____
Please print

Address _____
Code Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

SS# _____ Date of Birth: _____

Place of Work: _____ Occupation: _____

If attending school, which one? _____

Degree seeking: _____

Person to be notified in case of emergency:

Name _____ Phone _____

Address _____
Code Street City State Zip

Relationship to applicant: _____

How did you hear about the volunteer program at Hospice of Baton Rouge?

Why do you want to be a Hospice of Baton Rouge Volunteer?

If your interest in volunteering for Hospice of Baton Rouge is based on a need for community service/volunteer hours, please explain.

Have you experienced any major losses in your life? If so, please list and include month and year.

**Note: It is recommended that all applicants wait for a period of at least 12 months after experiencing a loss before they can serve as Direct Care Volunteers.*

Previous volunteer experience (please include name of organization and responsibilities):

Please list any special training, education, work/life experience that may be valuable for you as a Hospice of Baton Rouge Volunteer:

Hobbies you enjoy:

Anything else you would like to tell us about yourself:

Two Personal References (**excluding family members**) are required. Please provide a complete mailing address, as references are obtained by mail.

Name _____ Phone _____

Address _____
Code Street City State Zip

Relationship to Applicant _____

Name _____ Phone _____

Address _____
Code Street City State Zip

Relationship to Applicant _____

Identified areas of interest:

_____ Administrative / Office Volunteer

_____ Fundraising / Special Event Volunteer

_____ Bereavement Volunteer

_____ Direct Patient Care Volunteer

_____ Pet Peace of Mind Volunteer

Note: Direct Patient Care Volunteering requires 12 hours of training; Bereavement & Pet Peace of Mind Volunteering require an additional 3 hours of training each (provided by HBR Volunteer Services).

Please describe your availability for HBR Volunteer Services:

How would you describe your general health? Good _____ Fair _____ Poor _____

Do you have any physical restrictions that might affect your volunteer placement with Hospice of Baton Rouge? If so, please explain.

Do you have a means of transportation and a driver's license? _____

Please list if you are fluent in any other language besides English. _____

***Please fill out and return to:** **Hospice of Baton Rouge**
Attn.: Volunteer Coordinator
9063 Siegen Lane, Suite A
Baton Rouge, LA 70810
Fax: 225-769-8113
LSavage@hospicebr.org

Confidential Request for Reference

Our agency, Hospice of Greater Baton Rouge, which offers hospice care to terminally ill patients and their families, is considering _____, for a volunteer position. Because we require all applicants to provide us with references, we have been authorized by this applicant to request the following information from you. We will greatly appreciate and hold in strict confidence any information that you may give concerning him/her. Thank you for your time in providing us this valuable information.

Volunteer Coordinator Signature

I hereby request and authorize the release of any information required to complete this form. I agree to hold free of responsibility or liability Hospice of Greater Baton Rouge and anyone contacted by them should information found resulting in my being determined unacceptable for volunteering with this agency.

Applicant Signature

Date

Please evaluate this individual's abilities/skills in the following areas:

	Above Average	Good	Fair	Needs Improvement
Knowledge of Professional Skills				
Accepts Supervision				
Attitude/Cooperation				
Self Assurance				
Dependability/Punctuality				
Personal Appearance				
Ability to Cope with Stress				
Sense of Empathy/Compassion				
Poise/Self Control				

Comments: _____

Reference Person Signature/Title

Date



Reference Person

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Poise/Self Control				

Comments: _____

Reference Person Signature/Title

Date

Reference Person



HBR CORE VALUES

EXCELLENCE

Hospice as it should be.

Competent and professional care that is accessible to all people.

COMPASSION

We provide holistic care focusing on mind, body, and spirit.

We treat all patients, caregivers, employees, and volunteers with dignity.

We strive to be trustworthy and approachable.

INTEGRITY

Honest and accountable.

You can depend on HBR to do our best even when no one is watching.

Our staff and volunteers are proud to be serving the end of life care needs of our community.

STEWARDSHIP

We are responsible stewards of our time, talents, and financial resources.

We are supported by our community and give back to our community. We are called to serve.

TEAMWORK

A collaborative care model is at the core of our mission.

We strive to listen and speak respectfully to each other, to our patients, and to their caregivers. We share responsibility for the quality of the end of life care we provide. Teamwork is lived and embodied, not talked about!

I have read and understand the HBR Core Values and agree to fulfill my volunteer responsibilities in compliance with these standards.

Volunteer Signature

Date

Volunteer Coordinator Signature

Date

HOSPICE OF BATON ROUGE

MEMO



TO: VOLUNTEERS

FROM: AMY ZIETTLOW
Chief Operating Officer

CC: Volunteer Coordinator

DATE: January 1, 2010

RE: MOTOR VEHICLE RECORD CHECKS

HBR's Liability Insurance carrier requires us to run a Motor Vehicle Record Check (MVR) on all employees/volunteers at the time of hire and at least annually thereafter. This is a requirement for all employees/volunteers who drive as part of their hospice duties.

We will be running an MVR on all current employees/volunteers whose duties require driving in the next few weeks. If any questions or concerns come up as a result of your MVR we will furnish you with a copy and discuss what options may be available at that time.

Motor Vehicle Record Check Policy

A motor vehicle record (MVR) check will be made on all new staff and employees who will be driving as part of their job requirement. A MVR will be checked annually on all employees and volunteers who drive as part of their job requirement. Each driving employee must:

- Possess a valid driver's license issued by the state in which they are working with no physical limitation greater than the requirement to wear corrective lenses.
- Have no more than three moving violations or one chargeable accident in the prior 36-month period.
- Have no more than one major offense such as a DUI or Reckless Driving Conviction within the past seven (7) years.

Any employee/volunteer who does not meet these requirements may not work in a position that requires driving as part of their job.

If you have any questions or concerns, please see the Chief Operating Officer or Volunteer Coordinator.

Employee/Volunteer

Print Name

Date



AccuScreen Systems™
 1038 Main Street
 Baton Rouge, Louisiana 70802
 (225) 343-TEST



**BACKGROUND SEARCH
 INFORMATION FORM**

HOSPICE OF BATON ROUGE

Note to Applicant: The purpose of this form is to obtain information for AccuScreen Systems to conduct a criminal background search. This form will not become a part of an applicant's personnel file.

Employer: To insure an accurate search, please make sure this form is fully completed in clear print.
Email to dmorgan@accuscreensystems.com or fax to (225) 383-6445 or 343-9237.

Check all services requested:	Criminal -State Dist Court: <input checked="" type="checkbox"/>	Education: <input type="checkbox"/>	MVR: <input checked="" type="checkbox"/>
	Criminal -US Dist Court: <input type="checkbox"/>	References: <input type="checkbox"/>	Credit: <input type="checkbox"/>
	Professional License/Disciplinary Action: <input type="checkbox"/>	SSN Verification: <input type="checkbox"/>	OIG: <input type="checkbox"/>

Applicant's Full Name: _____ **Dates Used:** _____
 (First) (Middle) (Last)

***Social Security Number:** _____ ***Date of Birth:** _____

***Drivers License No:** _____ ***State Issued:** _____

Applicant's Complete Current Physical Address: _____ Apt. Number: _____
 City, State: _____ Zip Code: _____

***Residences:** List below all cities and parishes/counties in which the applicant has resided during the past **7 YEARS ONLY**. Please list the dates resided in each city and all last names the applicant used while living there **DURING THOSE 7 YEARS**.

(These boxes for office use only)	<input type="checkbox"/>	_____	_____	_____	_____
		(City, State)	(County / Parish)	(All Last Names used while living here)	(Mo.-Yr.) / (Mo.-Yr.)
	<input type="checkbox"/>	_____	_____	_____	_____
		(City, State)	(County / Parish)	(All Last Names used while living here)	(Mo.-Yr.) / (Mo.-Yr.)
	<input type="checkbox"/>	_____	_____	_____	_____
	(City, State)	(County / Parish)	(All Last Names used while living here)	(Mo.-Yr.) / (Mo.-Yr.)	
<input type="checkbox"/>	_____	_____	_____	_____	
	(City, State)	(County / Parish)	(All Last Names used while living here)	(Mo.-Yr.) / (Mo.-Yr.)	

***(Complete this section ONLY if you are requesting Employment Reference Verification)**

_____	_____	_____	_____
Company Name and Address	Co. Telephone No.	Contact Person or Supervisor	Employment Dates
_____	_____	_____	_____
Company Name and Address	Co. Telephone No.	Contact Person or Supervisor	Employment Dates
_____	_____	_____	_____
Company Name and Address	Co. Telephone No.	Contact Person or Supervisor	Employment Dates

By completing and signing this form you are authorizing AccuScreen Systems access to any active or inactive criminal records.

Applicant's Signature: (x)
 (If you are emailing this form, you may indicate the applicant's signature is on file at your office)

Person Requesting Search: _____
 (Please Print Clearly) Phone with Area Code

Additional Comments: _____

DEPARTMENT CODE _____

Promoting A Drug Free Work Environment

- Drug Testing • Criminal History • Driving Records • Employment and Education Verification • Nationwide Service •

Conflict of Interest Policy



Introduction

The purpose of this policy is to define what constitutes a conflict of interest so that an employee or volunteer may avoid such activities and to set guidelines for disclosing any actual and/or potential conflict of interest.

HBR respects each individual's right to engage in commercial, social, community, political or religious activities outside of his or her employment/volunteering which are private in nature. The performance of these activities may, however, result in an actual or potential conflict, or give the appearance of a conflict of interest situation. A conflict of interest occurs when an employee uses his or her position at HBR for individual personal advantage or advantage of a family member. In all business associations, both inside and outside HBR, officers, employees and volunteers should not permit themselves to be placed in a conflict of interest situation.

Policy

A conflict of interest arises whenever your interest or that of your immediate family conflicts or appears to conflict with the interest of HBR. Each employee/volunteer has a duty to avoid a conflict of interest or the appearance of a conflict of interest.

The following discussion is not intended to intrude upon your privacy but to help you avoid a conflict of interest. If you are faced with a personal transaction, decision, or situation which you think may create a conflict of interest, you are to report it to the Chief Executive Officer or Chief Operation Officer. In some situations, if there are no objectionable, legal or ethical issues involved, HBR may consent to the proposed activity even though a conflict of interest exists. Therefore, it is the policy of HBR that employees/volunteers:

1. Carry out the assignments as employees/volunteers of HBR with loyalty and faithfulness to one's obligations and duties to the organization and to bring credit to themselves and HBR exercising their best care, skill, and judgment for the benefit of the institution.
2. Refrain from activities which do or could or appear to create a conflict of interest.

Procedure

1. Possible, actual or the appearance of a conflict of interest situation must be reported to the Chief Executive Officer or Chief Operating Officer. The employee/volunteer will make a full disclosure of all facts and circumstances surrounding the actual or potential conflict of interest and the CEO or COO will then make a determination whether the employee/volunteer may pursue and/or continue the activity.
2. All employees/volunteers are expected to maintain an awareness of potential conflicts of interest and ensure compliance with procedure.
3. Employees/volunteers in violation of this policy may be subject to disciplinary action up to and including termination.

Employee/Volunteer Signature

Date

Hospice of Baton Rouge
9063 Siegen Lane, Suite A
Baton Rouge, LA 70810



VOLUNTEER AGREEMENT TO CONFIDENTIALITY

I, _____, as a volunteer of Hospice Foundation of Greater Baton Rouge, understand that any patient/family information to which I have access is privileged and shall be held in strict confidence. I agree to share patient/family information only with appropriate Hospice personnel.

I further understand that I have the right to legal representation provided by the Foundation should I be requested to testify about any hospice issues concerning a patient.

I also understand that should I provide, release, or discuss any patient and/or hospice related confidential information, it will be cause for immediate termination. This agreement does not alter the nature of my position as a volunteer.

Volunteer Signature

Date

Volunteer Coordinator Signature

Date

HOSPICE OF BATON ROUGE

9063 Siegen Lane, Suite A
Baton Rouge, LA 70810
(225) 767-4673
hospicebr.org

VOLUNTEER PRE-TRAINING INTERVIEW

(Fill out only if you plan to attend Direct Patient Care training.)

Name: _____ Date: _____

1. What are your reasons for wanting to be involved with Hospice?
2. What would be the most challenging part of working with Hospice?
3. What would be the most enjoyable aspect of this work?
4. What kind of support system do you have?
5. What do you do to have fun?
6. What would you like to contribute to the Hospice program?
7. What do you think the Hospice program can give to you?

To be filled out by Volunteer Coordinator

Received by

Date