Embracing Life
GATEWAY
HOSPICE

VOLUNTEER APPLICATION

Name _____ Date of Application _____

Address _____

_____ Home Phone _____

_____ Cell Phone _____

Email _____

Date you can start volunteering? _____/_____/_____

When is the best time to contact you and at which number? _____ ☐ am ☐ pm

When is your volunteer availability? ☐ Evenings ☐ Weekdays ☐ Weekends

Do you have any limitations that may prevent you from fulfilling volunteer visits? If yes, please explain: _____ ☐ Yes ☐ No

Have you ever pled "guilty" or "no contest" to or been convicted of a crime? If yes, please provide date(s) & details _____ ☐ Yes ☐ No

Telephone #: H: _____ W: _____ C: _____ Birth Date_____

Do you have previous volunteer/hospice experience? If yes, please explain:

_____

List special accomplishments, publications, awards, etc.

_____

List hobbies, activities, and additional information you would like Gateway to know about you:

_____

Please list 3 references we may contact :

_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

Volunteer Signature _____ Date _____/_____/____

Embracing Life

GATEWAY HOSPICE

GATEWAY HEALTH INC. NOTICE/DISCLOSURE AND AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization and consent for release of personal information acknowledges that Gateway Health Hospice (hereinafter referred to as "GATEWAY HEALTH HOSPICE") may conduct investigations. These investigations may include, but are not limited to: searches of financial or credit agencies, investigation of personal history, records of previous employment (including detailed information on work history), searches of educational institutions, military records, criminal history information on file in local, state or federal agencies, workers compensation records, and motor vehicle/driver's license records.

I understand that these searches will be used to determine employment eligibility under the GATEWAY HEALTH HOSPICE's employment policies. Therefore, I authorize and consent for full release of records (either orally or in writing) to the authorized representative of GATEWAY HEALTH HOSPICE. In addition, I release and discharge GATEWAY HEALTH HOSPICE and its agents and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs, expenses, or any other charge or complaint filed with any agency arising from retrieving and reporting this information. I understand that this notice will apply to any future update reports that may be requested and is valid for up to one year from the date below for hiring purposes. After reading this document, I understand fully its complete contents and I authorize the background verification.

In the event that information from the report is utilized in whole or in part in making an adverse decision with regard to your potential employment, we will provide you with a copy of the consumer report and a description in writing of your rights under the Federal Fair Credit Reporting Act.

Name _____ D.O.B _____ Social Security # _____

Driver's License # _____ State Issued _____

Current Address _____

City/State _____ Zip code _____ How long at this address? _____

Maiden name or other alias _____

Home phone _____ Work phone _____

Please list any other previous residences for the last 7 years (include address, city, state, zip code, and dates):

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

4. _____
_____
_____

_____ _____
Print Name Signature Date

NOTICE: You have the right to request disclosure of the nature and scope of our investigation and/or a written summary of your rights under section 609(c) of the federal Fair Credit Reporting Act by providing us with a written request within a reasonable time of our background investigation.

Volunteer Signature _____ Date _____/_____/____