



VOLUNTEERS' APPLICATION FORM



Name & Surname			Gender	
Home Address				Age
Tel. No.	Mobile No.	Next of kin tel no. In case of emergency	ID No.	E-Mail Address
Date of Birth	Nationality	Occupation	Full Time	<input type="checkbox"/>
			Part Time	<input type="checkbox"/>
Hobbies / Interests				
Do you have your own transport? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have experience in voluntary work? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, where and for how long? _____				
How did you learn about voluntary work at Hospice Malta?				
Why would you like to volunteer with Hospice Malta?				
When are you available to volunteer? (please specify, days, times etc.)				

Volunteer interest – please tick those areas of volunteering you are interested in

- | | | |
|--|---|--|
| Reception <input type="checkbox"/> | Administration <input type="checkbox"/> | PC work <input type="checkbox"/> |
| Driving <input type="checkbox"/> | Hydrotherapy <input type="checkbox"/> | Day Therapy <input type="checkbox"/> |
| Crafts Facilitation <input type="checkbox"/> | Baking/Cooking <input type="checkbox"/> | Children's Club <input type="checkbox"/> |
| Home Visiting <input type="checkbox"/> | Hospital Van <input type="checkbox"/> | Bereavement <input type="checkbox"/> |
| Helping at events <input type="checkbox"/> | Fundraising <input type="checkbox"/> | Memorial Masses <input type="checkbox"/> |

Are you aware of any allergies / medical conditions which we should be aware of? Yes No
(e.g. need of inhaler, insulin shot, allergy shot etc.)

Are there any conditions which may affect your ability to undertake the volunteering activities which you have indicated? Yes No

If yes please specify _____

Have you suffered a bereavement of a close relative or friend in the past two years? Yes No

Have you or any of your relatives ever used Hospice Malta's services? Yes No

Referees (please indicate details of two persons not related to you, who we may ask for a reference)

Referee 1

Name: _____

Address: _____

Tel No: _____ Mob No: _____

Referee 2

Name: _____

Address: _____

Tel No: _____ Mob No: _____

We look forward to receiving your application and will ensure that all information provided will be treated as confidential. Your details may be kept on a volunteer database and we may use the data to keep you up to date with other volunteering opportunities and news.

I understand that while volunteering with Hospice Malta, I may gain knowledge or receive information of a highly confidential nature. I therefore commit myself not to disclose any information acquired during my duties.

Signature

Date

For office use only

Date of interview

Interviewed by

Will volunteer undertake
a volunteering activity?

Yes

No

Date of Induction Course

Remarks _____

