St. Joseph Health
Hospice Services

SACKS
St. Joseph Health
Hospice Services

STUDENT VOLUNTEER APPLICATION

DATE: _____

NAME: _____ BIRTHDATE: _____

ADDRESS: _____CITY: _____ STATE: _____ZIP: _____

PHONE: HOME: _____ CELL: _____

NAME OF SCHOOL YOU CURRENTLY ATTEND:_____

BEST DAYS AND TIMES TO CONTACT YOU: _____

IN CASE OF EMEGENCY, PLEASE CONTACT:

NAME: _____PHONE: _____

ADDRESS: _____RELATIONSHIP: _____

1. HOW MANY COMMUNITY SERVICE HOURS DO YOU NEED? _____

2. WHAT DO YOU KNOW ABOUT HOSPICE?_____

_____

3. WHY WOULD YOU LIKE TO VOLUNTEER HERE? _____

_____