



**PATIENT VOLUNTEER TRAINING  
Registration Form – 2019**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**Educational Background**

Highest Level of Education: \_\_\_\_\_

Specialized Training: \_\_\_\_\_

Have you ever done any volunteer work?  Yes  No If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any physical limitations, disabilities, or chronic health problems that would affect your work as a hospice volunteer?  Yes  No If yes, please explain:

\_\_\_\_\_

Have you ever had a serious, life-threatening illness?  Yes  No If yes, please explain:

\_\_\_\_\_

Have you had a loved one die? If yes, please specify your relationship and when he/she died:

\_\_\_\_\_

Describe how you have coped with the death of a loved one or other significant loss:

\_\_\_\_\_

\_\_\_\_\_

Describe how you deal with stress: \_\_\_\_\_

\_\_\_\_\_

How would you describe your ability to communicate with others? \_\_\_\_\_

