



ST. FRANCIS HOSPICE  
HELPERS APPLICATION

Name: Miss/ Ms./ Mrs./ Mr. \_\_\_\_\_

Preferred Nickname: \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Cell Phone Number: (\_\_\_\_) \_\_\_\_\_

Home Mailing Address: \_\_\_\_\_

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

Work Phone Number: (\_\_\_\_) \_\_\_\_\_

Work Mailing Address: \_\_\_\_\_

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

Current Grade in School \_\_\_\_\_ Name of School \_\_\_\_\_

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

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

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

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

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: (\_\_\_\_) \_\_\_\_\_

Why Do You Want To be A Hospice Helper? \_\_\_\_\_

**TYPES OF SERVICE:**

The categories listed are general and not inclusive of all possible duties. Please mark those that interest you.

Office: Data Entry \_\_\_\_\_ Data Base \_\_\_\_\_

Sewing \_\_\_\_\_ Crafts \_\_\_\_\_ Assembling projects (forms, supplies, etc.) \_\_\_\_\_

Musical instrument (i.e. harp, piano) \_\_\_\_\_

**SKILLS**

Please list any skills in which you are experienced and would be willing to share with us: (i.e. typing, computers, sewing, and gardening)

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

Please complete the information below if you are helping Hospice to fulfill a community service hours commitment: (example: school, court, honor society, club, etc.)

Hours required by: \_\_\_\_\_

Reason hours needed: \_\_\_\_\_

Supervisor: \_\_\_\_\_

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

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

Hours needed: \_\_\_\_\_ Date hours to be completed: \_\_\_\_\_

**CONFIDENTIALITY AGREEMENT**

I understand that while helping St. Francis Hospice I may have access to verbal, written, filmed and recorded hospital and patient information. I understand that this information can only be shared with those who need to know it to do their job. I must keep this information confidential at all times both when helping hospice and when with family, friends and others in the community. I understand that I may receive disciplinary action, including dismissal as a Hospice Helper or legal action, if I violate this confidentiality pledge.

I guarantee by my signature that I have been informed of St. Francis's confidentiality policy concerning private information and its treatment.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_\_