



**OGLE COUNTY HOSPICE ASSOCIATION
and
OGLE COUNTY HOSPICE ASSOCIATION FOUNDATION, INC.**

Angel Treasures and Office Volunteer Application

Name of Applicant _____

_____ Birthday _____

Please Print

Optional for card list

Address _____

_____ City

_____ State

_____ Zip

Home Phone # _____

Work Phone _____

Occupation _____

Employer: _____

Person to be notified in case of emergency:

Name: _____

Phone: _____

Special Training/Work Experience _____

Hours Available

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

References: Please provide complete information as references are verified by mail.

Name _____

Address _____

Phone _____

Name _____

Address _____

Phone _____

CODE OF ETHICS FOR VOLUNTEERS

As a volunteer, I realize that I am subject to a code of ethics similar to that which binds the professional in the field in which I work. I, like them, assume certain responsibilities and expect to account for what I do in terms of what is expected of me.

I understand that any information that is disclosed to me while assisting the Ogle County Hospice is confidential and that this confidentiality is protected by the policies of the Ogle County Hospice.

I interpret "volunteer" to mean that I have agreed to work without compensation in money, but having been accepted as a volunteer worker, I expect to do my work according to standards set forth in the Volunteer Policies and Procedures.

I accept this Code for the volunteer as my Code, to be followed with care and compassion.

I hereby certify that statements made on this application are true and correct to the best of my knowledge. I understand that, by submitting this application, I authorize inquiries to be made concerning my employment and character for the purpose of determining my suitability as a volunteer. **I affirm to have read the volunteer Code of Ethics and agree to abide by its regulations. I agree to respect the confidentiality of any client information I may acquire in the course of my volunteer activities.** I affirm and represent that I have automobile collision and liability coverage within the amounts required by Illinois Revised Statutes, and will notify my insurance company as primary provider if I use my automobile in the scope of my volunteer duties with Ogle County Hospice. This information will be held in the strictest confidence.

Applicant Signature _____ **Date** _____

For more information contact: Volunteer Coordinator
Ogle County Hospice Association
421 Pines Road
P.O. Box 462
Oregon, IL 61061

**OGLE COUNTY HOSPICE ASSOCIATION
and
OGLE COUNTY HOSPICE ASSOCIATION FOUNDATION, INC.**

Angel Treasures and Office Volunteer Application