



OGLE COUNTY HOSPICE ASSOCIATION &
OGLE COUNTY HOSPICE ASSOCIATION FOUNDATION, INC.

VOLUNTEER APPLICATION

Name: _____ Date of Birth: _____
Address: _____ Spouse's Name: _____
_____ Employer: _____
Home Phone: _____ Email Address: _____
Work Phone: _____

HEALTH:

How would you describe your general health in the past year?

Good _____ Fair _____ Poor _____

Do you have any physical restrictions that might affect your volunteer placement with Ogle County Hospice such as bad back, allergies, hearing, vision or communicable disease?

Yes, specify _____

No _____

CURRENT WORK AND AVAILABILITIES SITUATION (check where appropriate):

_____ Retired _____ Homemaker

_____ Employed full time _____ Student

_____ Employed part time

Hours Available _____ Days Available _____

Signature _____ Date _____

Please mail this form to: Volunteer Coordinator
Ogle County Hospice Association
421 Pines Road
P.O. Box 462
Oregon, IL 61061