Volunteer Program
Overview and Application

The requirements for becoming a volunteer with Trellis Supportive Care vary depending on the volunteer position desired. Requirements and training are specified below for each volunteer position.

1. Prospective volunteers must complete the Volunteer Application and return it to :

   Trellis Supportive Care
   ATTN: Volunteer Services
   101 Hospice Lane, Winston-Salem NC 27103
   or
   Fax the completed application to: 336-331-1361
   ATTN: Volunteer Services

2. After the application is reviewed, a member of the Volunteer Services Department will respond to the application by email, phone or letter. A face to face interview may be requested.

3. Completed applications *do not* guarantee placement in a volunteer position.

4. Once the interview has been conducted, references are checked and the background investigation is complete, the applicant may be invited to an upcoming training.

5. All accepted applicants must complete the specific training required for the position.

6. Upon completion of training, Direct Care and Clinical Support Volunteers are expected to volunteer 2 to 3 hours per week for a minimum of one year or 100 hours.

- ***Volunteer Orientation*** provides an introduction and overview of Trellis Supportive Care and of the regulations regarding services provided.

-Direct Care Volunteer Training is an intensive 12 hour class required for any volunteer who has direct contact with patients or family members. This also includes Welcome Desk Volunteers for the inpatient facilities.

-Additional training may be required depending upon the volunteer role desired.

Thank you for your interest in volunteering for Trellis Supportive Care. If you have questions, please contact Volunteer Services at volunteer@trellissupport.org or by calling
336-768-6157 ext. 1560 or 1-888-876-3663 ext. 1560.

TRELLIS Supportive Care
Palliative • Hospice • Family Support

Volunteer Application

Personal Information
(please print)

Name: _____ _____ _____ _____
(First) (Middle Initial) (Last)
(Preferred Name)
Street Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____Email Address: _____

What is your preferred method of contact? _____

How did you hear about our volunteer opportunities? _____

_____

Do you have a loved one in hospice care at this time? ☐ Yes ☐ No

Have you experienced a significant loss within the last year? _____
If so, what was your relationship and when was the loss?_____

ONE YEAR RULE*: We ask everyone to wait for at least one year after experiencing a loss before applying to become a volunteer. We have found it takes at least this long to live with one's own grief before being able to help others.*

Emergency Contact Information

Name: _____Relationship: _____
Primary Phone: _____Secondary Phone: _____
Preferred Hospital: _____

Volunteer History

Organization	From (Mo/Year)	To (Mo/Year)	Position/Description of Role

Employment Experience

Employer	From (Mo/Year)	To (Mo/Year)	Position/Description of Role

Record Checks

Due to the serious nature of the work done by Trellis Supportive Care and the responsibility placed upon volunteers, we will conduct criminal history background checks before accepting an individual into the volunteer program.

Have you ever been convicted of a criminal offense? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Availability

(Please check all that apply)

____ Daytime _____ Evening _____Weekend

References

Please provide the name, complete mailing address and phone number of two professional or personal references. ***Family members are not an acceptable reference***.

Name: _____ Relationship: _____

Address: _____

_____

Phone: _____ Email (optional) _____

Name: _____ Relationship: _____

Address: _____

_____

Phone: _____ Email: (optional) _____

Questionnaire

1. Why do you want to become a volunteer with our organization?

_____
_____
_____

2. If you were told you only had six months to live, what would you do?

_____
_____
_____

3. What are your experiences with and/or personal philosophy on death/grief?

_____
_____
_____

4. In which geographic areas (zip codes) are you willing to volunteer?

_____
_____

Areas of Interest

Please identify the areas of service that interest you. (mark all that apply)

☐ * Hospice Home ☐ * Welcome Desk ☐ *Home Care ☐ *Nursing Facilities ☐***** Office Support

☐ **Notary Public ☐ **Complementary Therapy ☐ **Animal Assisted Therapy ☐ ******Haircuts

**** Requires 12 hour volunteer training class***

***** Requires 12 hour volunteer training class as well as additional specific training and/or certification***

☐ ~Speakers Bureau/Health Fairs ☐**~** Gardening ☐**~** Hospice Bingo at Nursing Facilities
☐ Church Liaison ☐Sewing ☐Baker ☐ Pantry Patrons
☐ Youth IMPACT (Middle school to college aged-please complete teen application)

~ Requires Volunteer Orientation

Are you a Veteran? If so, in which branch of the military did you serve? _____

List additional special skills & talents (i.e., multi-lingual, photography, hobbies/crafts or computer skills)

_____

_____

Signatures and Authorization

At times, information concerning a volunteer may be used in a press release, for fundraising purposes or other reasons deemed appropriate by Trellis Supportive Care By submitting this application, the volunteer provides consent for Trellis Supportive Care to use the volunteer's name, title, portrait, picture, video image, photograph, or any reproduction likeness or quotation of the volunteer's remarks for public information, fund-raising purposes, or other organization programs as approved by Trellis Supportive Care.

Trellis Supportive Care is not obligated to provide a placement, nor are you obligated to accept a position offered. Opportunities for volunteers are provided without regard to race, color, religion, gender, sexual preference or orientation, genetic information, national origin, age, disability, or veteran status.

I understand that all volunteers represent Trellis Supportive Care and are subject to the rules and regulations of the organization. I authorize the organization to acquire additional information from references included in this application and I hereby release them, their companies and Trellis Supportive Care from any liability whatsoever concerning this information obtained through this application.

The information provided has been completed thoroughly and truthfully by the Volunteer Services Program Applicant. This application and any other documents obtained during this application process will remain confidential in the Trellis Supportive Care Volunteer Services Office.

Applicant Name: (Please Print) _____

Applicant Signature: _____ Date: _____

Parent/Guardian Signature (if between the ages of 16-18:

_____ Date: _____

Revised 07/11/2019