



Dominican Home Health Agency, Inc.
VOLUNTEER APPLICATION

Dominican Home Health Agency (DHHA) depends on volunteers who have a heart and a desire to lend a hand to those less fortunate. We appreciate you giving your time, talent, and treasure to our Agency. We hope your time volunteering at DHHA will be fruitful and rewarding!

Date _____

Name _____ Nickname _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Phone Number: _____

Are you a student? Yes No If yes, what school: _____

Do you speak a foreign language? Yes No If yes, which language(s) _____

Have you ever been convicted of a crime other than a traffic violation? Yes No

If yes, what charge? _____

Date convicted: _____ Where? _____

Do you have any medical concerns that require any special accommodations? Yes No

If yes, please specify: _____

Education: (Circle highest grade completed)

High School: 9 10 11 12 College: 1 2 3 4 Graduate: 1 2 3 4

Major: _____ Degree(s): _____

Have you had any personal experience with any of these activities?

- Front Office Support (telephone/filing) Mailings/Bulk Mailings
- Data Entry /Spreadsheets (Word/Excel) Special Events
- Friendly Visits to Patients
- Seasonal projects (Gift wrapping, Christmas card mailing, etc.)
- Grounds maintenance/Gardening/Painting/Home Repair

Other relevant skills? Please explain: _____

Days and hours available to volunteer: _____

Work/Volunteer History:

Name, location, description of present or last employer or volunteer site: _____

Volunteer Dates: _____ Supervisor's name _____

May we contact your supervisor for a referral? Yes No Phone/Email _____

Please list two references:

Name _____ Phone/Email _____

Relationship _____

Name _____ Phone/Email _____

Relationship _____

Do you have any professional licenses/certifications relevant to your volunteer work at DHHA? Yes No

If yes, please list here:

License/Certificate # _____ State _____ Expires _____

License/Certificate # _____ State _____ Expires _____

Training and immunizations:

Current CPR/BLS Yes No *(preferred for clinical volunteers, but not required)*

TB Skin Test Yes No Date _____

Tetanus Shot Yes No Date _____

Hepatitis B Vaccine? Yes No Date _____

By submitting this signed application:

- I acknowledge that all of statements and information provided are true and accurate to the best of my knowledge.

-I agree to comply with Agency policy and procedures.

Printed Name

Date _____

Volunteer Signature

Please submit completed application to:
Ingrid Wicker - iwicker@dominicanhha.org Phone: 303-322-1413 Ext. 16 / Fax: 303-322-2702
2501 Gaylord Street, Denver, CO 80205

Your personal information obtained will be kept private and confidential and only shared with personnel involved in your volunteer work at the Agency.