

SPRINGHILL HOSPICE (ROCHDALE)

Broad Lane
Rochdale
OL16 4PZ
Tel: 01706 649920



(In Confidence)

VOLUNTEER APPLICATION FORM

Please complete in *block capitals in black ink or typescript.*

PERSONAL DETAILS

(Mr/Mrs/Miss/Ms/Dr)

FORENAMES: _____ SURNAME: _____

MAIDEN/PREVIOUS NAME: _____

DRIVING LICENCE HOLDER: YES/NO CAR OWNER: YES/NO NMC PIN No. (if applicable): _____

ADDRESS: _____

_____ POST CODE: _____

TEL: HOME _____ WORK _____ MOBILE _____

Email address:-----

AVAILABILITY am pm eve (Hospice only) am pm eve (Hospice only)

Monday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wednesday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thursday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Saturday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Hospice Shift times
 am = 9am – 1pm
 pm = 1pm – 5pm
 eve = 4.45 - 8pm

Are you available to volunteer for a limited time only? Yes No

If yes, please indicate dates available - From..... To.....

AREA(S) IN WHICH YOU WOULD BE INTERESTED:

Care Assistant	<input type="checkbox"/>	General Volunteer	<input type="checkbox"/>	Oldham Road Shop	<input type="checkbox"/>
Day Hospice	<input type="checkbox"/>	Driving	<input type="checkbox"/>	Yorkshire Street Shop	<input type="checkbox"/>
Complementary Therapies	<input type="checkbox"/>	Gardening	<input type="checkbox"/>	Littleborough Shop	<input type="checkbox"/>
Creative Therapies	<input type="checkbox"/>	Fundraising	<input type="checkbox"/>	Whitworth Shop	<input type="checkbox"/>
Beauty Therapy	<input type="checkbox"/>	Lottery	<input type="checkbox"/>	Furniture Shop (M'ton)	<input type="checkbox"/>
Reception	<input type="checkbox"/>	Flower Arranging	<input type="checkbox"/>	Heywood Shop	<input type="checkbox"/>
Bereavement Support	<input type="checkbox"/>	Craven Tea Rooms	<input type="checkbox"/>	Middleton Shop	<input type="checkbox"/>
Community Support	<input type="checkbox"/>			Emporium	<input type="checkbox"/>

HOSPICE SERVICE USER INFORMATION

Springhill Hospice welcomes volunteer applications from individuals who have used its services. However, processing of applications and commencement of volunteering will not normally be possible until 12 months after discharge. Other than as a visitor, have you used any of the services provided by Springhill Hospice within the last 12 months?

NO YES If YES, please provide the following information:

Service used -----

Are you currently using this service YES NO If NO, date on which you ceased using the service -----

ADDITIONAL INFORMATION ABOUT YOU

Please tell us a little bit about yourself. In particular, it would be helpful if you told us about any interests, hobbies, memberships, skills and experience that you have which you feel would support your application.

REFERENCES

Please give the names and addresses/email addresses of two referees, one of which should be your present/most recent employer if possible. Please note, it is your responsibility to ensure that your referees are aware they will be contacted for a reference.

- 1. _____

- 2. _____

REHABILITATION OF OFFENDERS ACT

This job may involve contact with patients. You must, therefore, declare any convictions you may have had including those considered as spent under the above Act. Any information given is, of course, in confidence and considered only in relation to the job for which you are applying. Do you have any convictions, reprimands or final warnings that are not 'protected' as defined by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended in 2013) by SI 20130 1198.

YES NO If YES, please send confidential letter of explanation to the Chief Executive at Springhill Hospice

PROFESSIONAL/REGULATORY BODY

Are you the subject of any current investigation or proceedings by a professional or regulatory body in the UK or any other country?
 YES NO If YES, please give details on a separate sheet of paper.

Have you ever been disqualified from the practice of a profession or required to practice under specific limitations?
 YES NO If YES, please give details on a separate sheet of paper.

Have you ever been referred to, or included on, a POVA list:
 YES NO If YES, please give details on a separate sheet of paper.

DATA PROTECTION NOTIFICATION:

(Please read carefully before signing this application)

The information you have provided in completing this application form will be used to process your application for volunteering. Springhill Hospice will keep the information you have supplied confidential and will not divulge it to third parties, except where required by law, or where we have retained the services of a third party representative to act on your/our behalf.

AUTHORISATION: I have read the Data Protection notification and understand and agree to the use of my personal data in accordance with the Data Protection Act 2018.

SIGNED: _____ DATE: _____

DECLARATION

I declare that the information given on this form and supporting documents, is complete and correct to the best of my knowledge. I understand that should I be employed by Springhill Hospice and at a later date this information is found to be incomplete or incorrect this may be considered as just reason to terminate my position as a volunteer.

SIGNED: _____ DATE: _____

**SPRINGHILL HOSPICE IS AN EQUAL OPPORTUNITIES EMPLOYER AND HAS A NO SMOKING POLICY.
 ALL POSTS ARE SUBJECT TO A DBS/POVA CHECK. IF YOU REQUIRE MORE INFORMATION ON THIS PLEASE
 REFER TO www.gov.uk/dbs**

For Office Use Only

DBS Reference Number _____ DBS Countersignature Signature _____

Date of Interview _____ Date Commenced _____

References Returned 1 2 Induction Attended _____