FRIENDS OF HOSPICE

Suite 124, 48 Par la Ville Rd., Hamilton HM 11
Phone: 232-0859   Fax: 232-2844
Email: hospice@bermudahospitals.bm

Agape House Student Volunteer Form

Date of Application ______________________ (Day Month Year)   Date of Birth ______________________ (Day Month Year)

Name   Miss/Mr. ____ (Surname First Middle)   Age _______

Mailing Address ____

Home Phone ____________________________   Email ______________________________________

Mother's Name __________________________________ Mother's Business Phone # __________________

Father's Name ____________________________________Father's Business Phone # ___________________

Guardian's Name ________________________________ Guardian's Business Phone # ________________

School Attending ____ Year _________________

School Guidance Counselor _____ ________________________________

Volunteer Service (please circle your interests):   Meal Service   Reception   Fundraising   Gardening

Office Assistance   Other _________________________

Available days and times: ____

Applicant's Signature ____

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For Office Use Only:

*Date Started*_____________   *Work Area*________________   *Days/Times* ____________________________

Orientation Completed _____________*Consent/Confidentiality Forms on File*_________
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