

VOLUNTEER SERVICES QUESTIONNAIRE

NAME: _____
ADDRESS: _____
PHONE NUMBER: _____ DATE OF BIRTH _____ SEX _____
NEAREST RELATIVE: _____
ADDRESS: _____
PHONE NUMBER: _____ RELATIONSHIP: _____

Have you ever performed Volunteer Services in a nursing home before? Yes No
If yes, where? _____

Do you enjoy working with Senior Citizens? Yes No

Do you have any relatives in this nursing home? Yes No If yes, what is the Residents name:

Have you ever had any relatives in a nursing home? Yes No If yes, where

Do you think, as a whole, nursing homes provide needed services? Yes No If no, please make comments as to how services could be improved.

_____ (use back of sheet if needed)

Do you have any physical limitations? Yes No If yes, please list:

Would you be willing to provide Volunteer Services to this Facility Yes No

How many hours can you donate: _____ Day _____ Week _____ Month

On what days would you be available: _____, _____, _____

What time of day would you be available? Morning Afternoon Night

Do you have any special talents you wish to share with our residents? Yes No
If yes, describe: _____

Do you play any musical instruments? Yes No Type _____

What type of services would you be willing to provide? (List in order of Preference)

If selected to participate in our Volunteer Program, do you agree to abide by the rules and regulations of this Facility? Yes No

DATE: _____ SIGNATURE: _____