HEALING PATCH
A Children's Grief Program

Volunteer Application

Thank you for your interest in becoming a volunteer for the Healing Patch Children's Grief Program. The information you provide below will be helpful as we work with you to identify the best fit for you.

Name: ________________________________

Address: ________________________________ **City/State:** _________________ **Zip:** _________

Cell Phone: (_____)________________ **Home Phone:** (_____)________________

Email: ________________________________

Date of Birth : ___________________ ***Please note that volunteers must be at least 21 years old.***

Volunteer Position Desired: ____

Why are you interested in volunteering? ____

____

____

How did you hear about this volunteer opportunity?____

____

Have you ever been convicted of a felony or misdemeanor? ☐ **Yes** ☐ **No**

If yes, please explain. A conviction may not disqualify you from the position sought:

____

Do you have a driver's license? ☐ **Yes** ☐ **No**

Do you have reliable transportation to attend volunteer roles? ☐ **Yes** ☐ **No**

EMPLOYMENT HISTORY

	Name of Company (+ City/State)	Start date:	End date:	Reason for Leaving	Supervisor Name
Current or Most Recent					
Previous Employment					
Previous Employment					

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EDUCATION HISTORY

	Name of School	Field of Study	Degree	Graduated: Yes or No?	Year Graduated
High School					
College/ University					
Graduate or Professional School					

Please list any other education or technical training that would assist you in this role:
____

REFERENCES
Please list at least three references, not related to you.

	Name and Occupation	How do you know this reference?	City & State	Email Address (Phone # if no email)
Reference 1				
Reference 2				
Reference 3				

My signature below indicates that all information contained in this application is true and correct. I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts on this application is cause for dismissal. If accepted, Healing Patch recognizes that all volunteers are accepted at will and that the volunteer relationship may be terminated at any time by either party, with or without cause, or for any reason with or without notice.

Signature: ________________________________ **Date:** ____________________________

It is the policy of UPMC to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Thank you for completing this application form and for your interest in volunteering with us!

Please submit completed form to:
Shalen Steinbugl, Volunteer Coordinator/Grief Specialist

Email: Steinbuglsm@upmc.edu
Mailing Address: Attn: Healing Patch, UPMC Home Healthcare, 20 Sheraton Drive, Altoona, PA 16601

If you have any questions, please call Shalen Steinbugl at 814-947-7140.
Once your application is received, you will be contacted to schedule an orientation.