

PROFESSIONAL HEALTH CARE

ANGELS OF HOPE ORIENTATION CHECKLIST

Volunteer Name: _____

Every activity applies to every volunteer to a greater or lesser degree. All activities must be completed for each volunteer.

<u>Section 1 – Introduction to Hospice</u>	<u>Date of Completion</u>
1. Philosophy of Hospice	
2. Hospice Care	
3. Hospice Services	
4. The Patient's Bill of Rights	
<u>Section 2 – Death & Dying</u>	<u>Date of Completion</u>
5. Working with the Dying	
6. The Dying Process	
<u>Section 3 – Volunteer Services</u>	<u>Date of Completion</u>
7. Volunteers in Hospice	
8. Volunteer Qualities	
9. Volunteer Roles	
10. Volunteer's Bill of Rights	
11. Code of Ethics	
<u>Section 4 – Volunteer Visits</u>	<u>Date of Completion</u>
12. Visitation Guidelines	
13. Do's & Don'ts	
<u>Section 5 – Required Paperwork</u>	<u>Date of Completion</u>
1. Volunteer Application	
2. Criminal History Release Form	
3. DPS Computerized Criminal History Verification	
4. Confidentiality Agreement	
5. HR Requirements Form	
6. HIPPA Basics	

CONFIDENTIALITY STATEMENT:

I acknowledge that I must maintain confidentiality of all patient care and employee information to ensure patient and employee rights are protected, per Professional Health Care. I also acknowledge I will have to access patient information and have been given specific training on HIPPA Privacy Regulations and have complete understanding of my obligation to protect patient/client information.

ACKNOWLEDGEMENT OF UNDERSTANDING:

I have read, been orally instructed, been given a copy, understand, and will comply with all of the policies and procedures listed for Professional Health Care.

VOLUNTEER SIGNATURE

DATE

PROFESSIONAL HEALTH CARE REPRESENTATIVE

DATE