



The Heart Touch™ Project

Heart Touch Training in Compassionate Touch Application

GENERAL INFORMATION

Please print legibly above each line.

Date of Training

First Name

M.I.

Last Name

Street Address

Suite/Apt No.

City

State

Zip Code

() _____

Home Phone

() _____

Cell Phone

Email Address (*our primary means of communicating with you*)

Social Security Number: _____ (required for background check)

Sex: Male Female

Date of Birth: _____ / _____ / _____
Month Day Year

Occupation

Employer

Education completed: _____ Degree _____

Language(s) spoken _____

Have you ever been convicted of a felony? Yes No

If yes, explain _____

Do you have access to reliable transportation to perform your volunteer work? Yes No

Do you have a valid California driver's license? Yes No

Do you have automobile liability insurance? Yes No

Ethnicity (optional): Hispanic/Latino White Black/African American Asian

Native American Pacific Islander Other

VOLUNTEER INTEREST

Are you interested in becoming a volunteer at a hospice? Yes No

Most hospices require a one year commitment. Are you able to volunteer for one hour a week for one year (a total of 48 hours/year)? Yes No

Would you be willing to travel to your client's home? _____

If yes, to what areas would you be willing to travel? _____

What skills, talents and interests do you have that could apply to working as a volunteer?

If you have previous volunteer experience, what have you enjoyed the most? _____

What have you enjoyed the least? _____

PRACTITIONER INFORMATION

(If applicable)

What type of healthcare practitioner are you? (i.e., massage therapist, nurse, chiropractor, physical therapist, acupuncturist, etc.)

If you are a massage therapist, do you have a city issued license or State of California certification?

Yes No

If a city license, provide name of city _____

City License Number _____

If State of California, indicate status: Certified Massage Therapist Massage Technician

State of California Certification Number _____

List other bodywork certifications you have obtained. _____

Educational background/training: _____

If you currently working as a healthcare practitioner, please supply the name and location of the business.

If you an active member of any professional organizations, please list their names.

HEALTH SCREENING

Have you ever been tested for TB? Yes No Results: _____

Do you have access to your immunization records?..... Yes No

Briefly describe the condition of your current health: _____

If you currently carry malpractice insurance as a healthcare worker, please list your carrier.

CLIENT KNOWLEDGE

Are you knowledgeable about hospice care, HIV/AIDS, Alzheimer's, dementia, premature infants, or children with special needs? Yes No

If yes, please explain: _____

Are you knowledgeable about any other illness or condition? _____

Do you currently work with AIDS, hospice care patients, hospitalized children, and/or seniors?
 Yes No If yes, which population and in what capacity? _____

Do you have concerns associated with working with AIDS or hospice care patients, seniors or special needs children? Yes No
If yes, what are your concerns? _____

APPLICANT COMMENTS

What are the important losses in your life and their approximate dates? (e.g. father's death in 2005)

REFERENCES

Reference #1

Name: _____ Relationship: _____

Phone number: () _____

Reference #2

Name: _____ Relationship: _____

Phone number: () _____

Reference #3

Name: _____ Relationship: _____

Phone number: () _____

EMERGENCY CONTACTS

Contact #1

Name: _____ Relationship: _____

Phone number: () _____

Contact #2

Name: _____ Relationship: _____

Phone number: () _____

COMMITMENT TO PARTICIPATE

I, _____, am committed to participating in the Heart Touch Training in Compassionate Touch and I have cleared my schedule so that I can participate. I have written the dates for this training into my calendar or schedule.

If I cannot participate in this training, I agree to contact the Heart Touch office as soon as I know of this change. I understand that a refund of \$200 will be made if cancellation is made up to three days before the training. No refunds will be made if cancellations are received two days or less before the scheduled training.

(Please sign and date):

Signature: _____

Date: _____

FORM OF PAYMENT

The fee for Heart Touch Training in Compassionate Touch is \$250.00. Payment is due at the time you submit your application. An application is not complete unless payment is received.

Please indicate method of payment.

Check # _____ payable to The Heart Touch Project

Credit Card MasterCard Visa Discover

Name on Card: _____

Card Number: _____ Exp. Date: _____

SUBMITTING YOUR APPLICATION

Print and mail your application to the address below. If you did not complete the credit card information section in the application, please remember to include a check for \$250.00.

The Heart Touch Project
3400 Airport Avenue, Suite 42
Santa Monica, CA 90405

If you would like more information or have questions about Heart Touch Training in Compassionate Touch, please call Jennifer at 310-391-2558 or send an email to jennifer@hearttouch.org.