Hospice Orillia

Volunteer Hours
Monthly Report Form

Volunteer: _____

Month/Year: _____

Date	Client's First Name or Volunteer Activity	Phone or In-person	Travel Time (if applicable) (.25hr, .5hr, .75hr, 1hr)	Length of Visit/Activity (.25hr, .5hr, .75hr, 1hr)

Note: Significant changes in client condition are to be called in to the Hospice.

Confidentiality: The information contained in this facsimile message is privileged and is intended exclusively for use by the recipient named above. If you receive this facsimile in error, please notify us immediately by telephone and return the original document by mail to the above address.

Please return this form to:
10 Peter Street North, Suite 301, Orillia, ON, L3V 4Y7
Tel: 327-7799 Fax: 327-5986 Email: office@hospiceorillia.org

Revised April 24, 2009