



Dear Prospective Volunteer,

Thank you for considering our Bereavement Camps as a place to give of your time and talent. Our Bereavement Camps [Camp Courage I and Camp Courage II] and our Pre-Camp Grief Support Group Sessions, offer children and teens (8–18 years of age) and their families a safe place to share their feelings of grief and to learn coping skills to help them on their grief journey. The Camps and the Pre-Camp Support Group Sessions are the bereavement outreach of Geisinger Home Health & Hospice, a not-for-profit organization, and are made possible through grants, fund-raising activities and the generosity of volunteers and donors in our community. The weekend camps, Camp Courage I (in May) and Camp Courage II (in October), are held at Camp Victory, a beautiful camp village located in Millville, Pennsylvania. The Pre-Camp Grief Support Group sessions are held before each camp at The Village in Evers Grove, Pennsylvania. **The Bereavement Camps and the Pre Camp Grief Support Group Sessions are free to all children and families who attend.**

One of our main needs is for “Big Buddies” who are willing to provide one-to-one support, companionship and supervision for a camper throughout the entire camp weekend/day. We also need “Support Volunteers” willing to offer blocks of time to assist with camper registration, sports activities, arts/crafts and a variety of free time activities.

If you are interested in helping with our Bereavement Program, please fill out the enclosed application. We have attached a guide to direct you in the completion of the application process. In order for us to plan for camp, the completed Volunteer Application must be returned to us as soon as possible so that we may complete the process. Please be aware that all of the precautions we take are necessary to protect the campers.

We know that the Bereavement Camps are truly special experiences for the children who attend and also for those who help make it possible. If you have any questions, please contact us at 570-784-1723 / 800-349-4702 or via email at [bereavementcamps@geisinger.edu](mailto:bereavementcamps@geisinger.edu).

Thank You for your interest in our Bereavement Camps!



## BEREAVEMENT CAMP VOLUNTEER APPLICATION PROCESS

### Camps for Grieving Children and Teens

**Step 1:** Complete, date and sign the application where indicated. Three Volunteer Reference Forms should also be attached to your completed application and mailed to:

Geisinger Home Health & Hospice  
Bereavement Program  
Attn: Bereavement Camps  
410 Glenn Avenue Suite 200  
Bloomsburg, PA 17815

**Step 2:** When we have received your completed application we will be touch.

**Step 3:** Once you have successfully completed the application, you must complete the following clearances: Act 34 Child Abuse Clearance, a Criminal Background Check and FBI fingerprinting. **If you have had these clearances done within the last year, please include a copy with your application.** If you have not, the Agency will provide you with the necessary forms and pay for the clearances to be processed.

**Step 4:** If steps 1 – 3 have been successfully completed, you will be asked to attend a mandatory Training Session.

If you have any questions or concerns, please contact us at the Bereavement Camps: (570) 784-1723 or (800)-349-4702. You can also contact us via email at [bereavementcamps@geisinger.edu](mailto:bereavementcamps@geisinger.edu).



<p>Attach your photo here. <b>REQUIRED</b></p>	<p><b>Volunteer Application</b> <b>Bereavement Camps</b> <b>Camps for Grieving</b> <b>Children &amp; Teens</b></p>
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Today's Date: \_\_\_\_\_

Volunteer's Full Name: \_\_\_\_\_

Prefer to be called: \_\_\_\_\_ Circle Gender: Male Female

Volunteer's Address: \_\_\_\_\_

(city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

County of Residence: \_\_\_\_\_ Volunteer's Date of Birth \_\_\_\_\_

Volunteer's Phone Number (s): \_\_\_\_\_

Volunteer's Email Address: \_\_\_\_\_

How did you learn about Camp Courage?

Each year we purchase shirts for our campers and volunteers. Please circle your preferred size:

Adult sizes: Small Medium Large XL XXL XXXL

Education/Special Training that may be relevant to the Bereavement Camps:

Past/Current Volunteer Work:

Employment: (company, position, dates). Please list most recent first.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please include three letters of reference when you return this application (attached at end of application). Please list the names of those references below:

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**History of Death of Loved Ones/Grief:**

Describe any personal experiences with death, dying, grief or serious illness:

Are you currently doing any personal grief work?

In what areas do you need to learn and grow while doing this type of volunteer work?

**Bereavement Camps  
Volunteer Health History**

Volunteer Name: \_\_\_\_\_

In case of emergency, contact:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Year of last Tetanus Booster: \_\_\_\_\_ (current tetanus vaccination is strongly suggested prior to attending camp). Protection is usually good for 10 years.

Date of last physical exam \_\_\_\_\_

Describe any personal health problems/issues or allergies:

Do you have any special needs or physical limitations/restrictions on activities while at camp?

Are you currently under the care of a physician for any medical problem?

Do you take any physician-prescribed medication on a regular basis? If yes, please explain:

Medical Insurance Information. Please attach a copy of current insurance card(s).

Company: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Preferred Physician/Medical Facility: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

**Bereavement Camps  
Authorization for Emergency Medical Treatment**

Volunteer's Name: \_\_\_\_\_

Should a medical emergency arise during my participation in Bereavement Camp activity and I am unable to speak for myself, I consent to:

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility deemed most fitting to the type of illness or injury, the Bereavement Camp Nurse or Coordinator Bereavement Camps, and
2. The immediate administration of life-sustaining measures deemed necessary under the circumstances.

\_\_\_\_\_  
**Initials**

**Bereavement Camps  
Volunteer Release of Liability**  
(This signed release is required for camp attendance)

I hereby release and discharge Geisinger Home Health & Hospice, its agents, employees, volunteers, and officers from any legal responsibility and/or liability for any personal injuries or illnesses, either physical or emotional; or injury to property, real or personal, whether injury is due to negligence or any other fault, which may occur during my attendance at the Bereavement Camps.

\_\_\_\_\_  
**Initials**

Volunteer's Name: \_\_\_\_\_  
(please print)

**I have read this Authorization, Release and Permission and agree to all of its terms.**

\_\_\_\_\_  
Signature of Volunteer

\_\_\_\_\_  
Date

**If volunteer is under the age of 18, signature of parent/guardian is required.**

\_\_\_\_\_  
Signature Parent/Guardian

\_\_\_\_\_  
Date

## VOLUNTEER REFERENCE FORM

Please complete the form below. It is the volunteer applicant's responsibility to return the form with his/her application to Geisinger Home Health & Hospice, 410 Glenn Avenue, Suite 200, Bloomsburg, PA 17815.

Thank you in advance for your cooperation.

Name of Volunteer Applicant: \_\_\_\_\_  
(Please Print)

Volunteer is applying for work with: (Please check one of the following.)

Hospice     Maria Hall     Bereavement Camps

1. How long have you known the applicant and in what relationship/capacity?
2. How does he/she communicate/interact with others?
3. What can you tell us about his/her personality, dependability and ability to work with others?
4. How do you feel the applicant will relate to and work with children ages 8 – 18 years of age in the camp setting? (applies only to Bereavement Camp Volunteers)

5. Can you describe any reason(s) you would hesitate to recommend the applicant for work with Geisinger Home Health & Hospice?

6. Any additional comments you would like to share about the applicant?

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Signature

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Date

**Note: References may not include family members.**



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