



OF SANTA BARBARA, INC.
A Volunteer Hospice Organization

VOLUNTEER MONTHLY REPORT

Volunteer name: _____ For the month of: _____

Training and Support

- Attended Volunteer Support Meeting _____ Date: _____
- Attended other HSB training: _____ Date: _____

Volunteer Hours

Date	*Service Provided	Visit (PC Only)	Hours Spent	Patient/Client Name (if applicable)	Notes and Observations
1/1/08	PC	✓	2	Jane Doe	Called Jane and saw her at home

Please submit to Volunteer Services by the **8th** of each month.
2050 Alameda Padre Serra, Suite 100, Santa Barbara, CA 93103
Email: dvandermey@hospiceofsantabarbara.org Fax: 805.563.8821

THANK YOU!

*Service Provided

- PC:** Patient Care- Any time spent with or for a patient. Includes communication and case conferences with Social Worker, Case Management Team, and other volunteers, calls to set up a visit, travel time, companionship, transport, shopping, phone calls, etc. **for a patient.**
- AD:** Administrative- Program support, set up for meetings, phone calls, mailings, etc. **for HSB office.**
- NO:** No One Dies Alone - Time spent specifically vigiling at the bedside.
- CT:** Complementary Therapy- Reiki, massage, healing touch, and cranial sacral therapist only.
- BVH:** HSB Bereavement- Bereavement administrative work, mailings, and phone calls for **HSB.**
- BVP:** PCCT Bereavement- Bereavement administrative work, mailings, and phone calls for **PCCT.**
- LR:** Life Reminiscence- Time spent specifically with the Life Rem. program including interviews and prep work.
- PET:** Pet Therapy- Time that you and your pet companioned a patient.
- SB:** Speakers Bureau- Please note location, date, and details of event.
- Other:** Explain

For office use only

VTR:	Vts:	PC:	CT:	BVH:	BVP:	AD:	CC:	LR:	PET:	SB:
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