McLEOD HOSPICE
VOLUNTEER ACTIVITY RECORD

Volunteer Name: _____ Patient Name: _____

Month: _____ Year: _____

DATE	*ACTIVITY CODE*	*VISIT TIME*	*TRAVEL TIME*	*ODOMETER START**	*ODOMETER END**	*COMMENTS*

TYPES OF ACTIVITIES	CODE
Home Visit	18
Hospital Visit	47
Inpatient Hospice Visit	47
Telephone Contact	VPHC
Hospice House Devotional	115
Hospice House Reception Desk	116
Hospice House Nursing Station	116
Bereavement Visit	VLBV
Bereavement Phone Call	VBPC
Funeral Visit	VLFV
Delivery	16
Clerical/Office	VLOF
Fundraising	55
Monthly Meeting	15
Inservice	88
Public Relations (Includes Health Fairs)	103
Tuesday Tea	TEA
Other (Specify in Comments)	51

_____
Signature, Hospice Volunteer Date

If medications delivered, please have caregiver sign here:

I received medications from the hospice volunteer:

_____
Signature Date

_____
Signature Date

_____
Signature Date

_____
Signature Date

*Odometer readings are required for mileage reimbursement.

7/05, 10/07, 3/08