



# IOWA CITY HOSPICE

## Volunteer Time Sheet

*Please remember to fill out a separate timesheet for each patient you volunteer to visit. Please complete the Charting Comments section of this form. Please remember to sign this form.*

Patient's Name: \_\_\_\_\_

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

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

*Please mail completed form to:* Jessica Hanlin, Patient Care & Volunteer Coordinator  
Iowa City Hospice  
1025 Wade Street, Iowa City, IA 52240

Date	Direct Patient Care	Type of Contact	Program Support	Bereavement	Travel Time	Time spent with Pt. Or Family	Total Hours
Example	P/E	HV			.5	1.5	2

**Codes:**

**Direct Patient Care:** P/E personal/environment; T transport; TM take in meal; CC child care; EH eleventh hour

**Program Support:** C/A clerical, office, mailings; FR fund raising; C/P committee/programs; IS/T in-service training; SB speaker's bureau

**Type of Contact:** HV: home, hospital, nursing home; TC: telephone call

Date	Charting Comments

Complete and return to Iowa City Hospice by the 5th and 20th of each month. Questions? Call 319.688.4200 or email [volunteer@iowacityhospice.org](mailto:volunteer@iowacityhospice.org)