# Volunteer Hours Report

cascade HEALTH SOLUTIONS
Hospice Care

VOLUNTEER NAME**:** _____MONTH/YEAR:_____

Please enter total time by category here:

| | |
|---|---|
| **O=Office Work Hours** | |
| **P=Pt. Care Hours-Hospice *** | |
| **E=Education/Training Hours** | |
| **TP=Transitions Pt. Care Hours*** | |
| **TOTAL HOURS** | |

(* Remember: *patient care hours should include phone call and travel time*. Round to nearest ¼ hour)

| **Service Date** | **Client Initials (not full name) and Service provided:** *(ex: Patient V.C. – visit and read)* | **O** | **P** | **E** | **T.P.** | **Total Time** |
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| | ***Total Time*** | | | | | |

**Please mail, email or fax your completed form at the end of each month. Thank you!**

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