Due by the 5th of the month following service

Living at Home of the Park Rapids Area

Report of Volunteer Hours

M

Volunteer's Name_____

(Please print)

Please round to the nearest ¼ hour

Date	Care Receiver (First and Last Name)	Type of Service (See below)	Home Visit?	Comments/Concerns	Time Spent (include all phone time, driving time, and time with the senior)	Number of miles (round trip)	Did Care Receiver accompany you? (circle yes or no)	Reimburse Mileage? (circle yes or no)
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
			Yes No				Yes No	Yes No
					Total Miles			

Type of Service:

Fundraising(FUND) Gardening(G) Handyman(H) Housekeeping(HK) Meetings(MTG)
Ramp Building(RMP) Shopping/Errands(SE) Transportation(T) Telephone(TEL) Training(TRN) Visiting(VST)

Remarks_____

SIGNATURE_____ DATE _____

Mail to
PO Box 465
Park Rapids, MN 56470

e-mail to:
volunteer@parkrapidslivingathome.org

Fax to
218-237-3137

Deliver to
17261 State Highway 34