



Health Ministries Network Volunteer Hours Reporting

This survey is designed to be quick and easy and involve little description. Please select from dropdown menus. You DO NOT have to answer every question. You DO have the option of adding description to each question, but this is not required.

1. For what month(s) are you reporting hours

2. Who completed these hours (first and last name)?

3. What is the name of the community served (may be a faith community, geographic community or other)?

4. Describe the service (in person or remote/distant) performed during this period by selecting from options in the drop down menu. If activity isn't covered here, please describe below.

	Yes/No	# minutes	# individuals served	# classes or group sessions held
Blood pressure check	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transitional care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Palliative care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transitional care	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other visit (i.e. spiritual care)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Individual Advance Care ed/assist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group Advance Care ed/assist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Referrals to community programs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Support group hosting or assistance (i.e. addiction/recovery)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Teach, lead or organize preventive health ed. not listed here. Describe below.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Community program support (food, writing, prayer, etc.)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mentorship to other FCNs or HMs	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other. Please describe any activities that are not covered here.

5. Describe the continuing education activities that you participated in during this period.

	Yes/No	Number of hours
Attend HMN monthly meetings	<input type="text"/>	<input type="text"/>
Attend professional education (for CEs)	<input type="text"/>	<input type="text"/>
Attend professional education (no CEs)	<input type="text"/>	<input type="text"/>
Attend spiritual formation	<input type="text"/>	<input type="text"/>

Other (please describe any education not covered here or indicate additional hours)

6. How would you improve this survey?

7. What type of support or continuing education would you like to receive from HMN?

8. If you would like a copy of your survey to be sent to you for reporting elsewhere, please include an email address here: