DEARBORN COUNTY HEALTH DEPARTMENT
VOLUNTEER APPLICATION

All information will be treated confidentially. Please answer all questions as completely as possible.

Personal Information

Last Name:	First Name:	**Credentials:** (MD, RN, RT, EMT, etc):
Address:	City/State:	Zip Code:
Email:		
Home Phone:	Business Phone:	Cell Phone:

Emergency Contact:

Name:	Relationship:
Day Phone:	Evening Phone:

Availability:

Are you interested in assisting during preparedness exercises or drills?	☐ Yes	☐ No
Assuming you are available to help during an actual public health emergency, how many hours per day would you consider serving as a volunteer?	☐ 12 hours	☐ 8 hours

Type of Volunteer:

☐ Non-Medical Volunteer	☐ Medical Professional (specify field)
☐ Administrative Professional	☐ Trained Responder (specify field)
☐ Law Enforcement Volunteer	☐ Other (specify):

Additional Skills and Abilities:

☐ People Skills	☐ Public Speaker
☐ Financial Background	☐ Administrative Professional
☐ Experience with Children	☐ Bilingual [specify language(s)]:
☐ Typist	☐ Other (specify):

Licenses: (Drivers and Professional) *Please note: all medical licenses are subject to verification.*

#1 Type:	State:	Number:	Expiration:
#2 Type:	State:	Number:	Expiration:
#3 Type:	State:	Number:	Expiration:

Volunteer's Signature: _____ Date: _____

The Volunteer Agreement is on the flipside of this document. Please complete both sides before submitting to the Dearborn County Health Department.

Dearborn County Health Department
Douglas Baer, Env. & Preparedness Supervisor (812) 537-8841 or
Lois Franklin, Nursing Supervisor, (812) 537-8843
Fax: (812) 537-1852 or (812) 537-6302

VOLUNTEER AGREEMENT

I am a volunteer applicant for the **Dearborn County Health Department**. I understand there are certain conditions to serve as a volunteer for the Local HD. I understand that this is a non-paid position.

1. Availability

If I am available, I am willing to serve on clinic assignments within the Dearborn County area for indefinite periods depending on the needs of the clinic operations. The average assignment is approximately 2-4 days in shifts of 8 – 12 hours and takes place within high-pressure work situations in adverse conditions such as long and irregular hours, erratic and inappropriate food, crowds, and noisy environment. I understand my assignment may be extended or curtailed in accordance with applicable Health Department polices, procedure and staffing requirements, determined at the discretion of the **Dearborn County Health Department**.

2. Work Performance

I am willing to comply with directives issued by the Operations Chief and my assigned supervisor. I will uphold and follow the policies and guidelines of the clinic. I understand that I may be released from an assignment and or removed from the LOCAL HD for violation of policy or a personnel/performance issue.

3. Permission to Perform Background Check

I verify that I have never been convicted of a felony or of a misdemeanor resulting in imprisonment within the last 24 months. I hereby allow the Local HD to perform a check of my background, including any of the following:

- Criminal record
- Driving record
- Past employment/volunteer history
- Educational/professional status
- Personal reference
- And other persons or sources as appropriate for the volunteer assignment in which I have expressed an interest.

I understand that I do not have to agree to this background check but that refusal to do so may exclude me from consideration for some types of volunteer work. I understand that information collected during this background check will be limited to the appropriate information to determine my suitability for particular types of volunteer work and that all such information collected during the check will be kept confidential.

I hereby also extend my permission to those individuals or organizations contacted for the purpose of this background check to give their full and honest evaluation of my suitability of the described volunteer work and such other information as they deem appropriate.

4. Status

I understand that I must update this form as soon as any changes in the above occur and submit an updated form on an annual basis.

I fully understand the mandatory requirements indicated above and certify that I am able to comply with them. If these statements are found to be incomplete or untrue, I understand that my enrollment with the Dearborn County Health Department may be terminated.

5. Liability

I understand that the **Dearborn County Health Department** is not responsible for any loss, illness or liability I may incur while serving as a volunteer.

Printed Name of Volunteer: _____

Signature of Volunteer: _____

Parental Consent, if under age 18: _____

Date: _____

For Office Use Only

Please initial behind any written responses.

Date of License #1 verification: _____ Date of License #2 verification: _____ Date of License #3 verification: _____

Date of background check: _____ Type of background check: _____ Finding(s) of background check: _____

Additional Information: _____

_____

_____

_____

Signature of Volunteer Director or Designee: _____ Date of Signature: _____