Champions of a safe and healthy community
Logan County Health District
310 S. Main St. Bellefontaine, OH 43311
PH:937-592-9040 FAX:937-592-6746

Volunteer Registration Form

Please print clearly. Submit to Logan County Health District or email/fax (see reverse)

Mr.__Mrs.__Ms.__Name_____ Birth Date (if under 18 years of age)_____

Day Phone_____ E-mail address _____

Home Address_____

City_____ ST_____ Zip_____

Emergency Contact_____ Relationship_____ Emergency Phone_____

Your Occupation_____

Employer_____

Business Address_____ City_____ ST_____ Zip_____

Times you are available _____

If you have any health limitations, please explain_____

Special skills and/or training: _____

_____

Languages other than English (specify proficiency) _____

If so, would you be interested in providing language interpretation if needed for conversations with customers or written documents Yes _____ No _____

Please list two character references (can be a current employee of the Health District)

Name _____ Phone number _____

Name _____ Phone number _____

Interests: Please check all that apply.

____ Clerical – filing, copying, mailings, creating packets of information or supplies

____ Data entry – Software: _____

____ Computer applications: ___Publisher documents ___Word documents ___Excel (creating graphs and charts)

____ Web page design ____ Create Newsletters or Reports ____ Power Point Presentations

____ Sorting/packing/cleaning

____ Assist at annual walk (registration, hand out information, put up signs, lead warm up, DJ, clean up)

____ Distribution of flyers or signs in the community (must provide your own transportation and vehicle insurance)

____ Editing documents (grammar, spelling, ease of reading)

____ Functional needs support (sign language, other) _____ Creating simple reading materials_____

____ Participate in Emergency Exercises

____ Public Health Initiatives ____ Health Fairs ____ Public Health Week

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CONFIDENTIALITY INFORMATION STATEMENT

I, _____, a volunteer at Logan County Health District (LCHD), hereby acknowledge that in the course of my service I may have exposure to confidential information about LCHD patients or clients from a variety of sources. Personal Health Information (PHI) is strictly confidential and must be protected. I hereby agree to disclose no confidential information. Further, when a patient or client's health history is reviewed, all reasonable measures will be taken to ensure privacy. If I have reason to believe that confidentiality has been breached, even if it was accidental, I will report this as soon as possible to the LCHD Privacy Officer, or to the LCHD employee supervising my duties.

I also acknowledge that I am aware of the provisions of the Health Insurance Privacy and Accountability Act (HIPAA) regulations concerning privacy, confidentiality and security. Further, I have been given the opportunity to ask questions and understand what is expected of me.

_____ _____

Signature Date

_____ _____

LCHD Privacy Officer Date

Release from Liability Statement

IN CONSIDERATION of the opportunity to participate as a volunteer with the Logan County Health District (LCHD), I, _____, understand there are certain risks and hazards associated with the volunteer activities in which I am participating. The risks and hazards have been fully explained to me and I understand the safety precautions to be observed to minimize these risks.

I fully assume the risks involved as acceptable to me and I agree to use my best judgment in undertaking these volunteer activities and follow all safety instructions.

I waive and release Logan County Health District from all personal injury and liability that may result from my participation in these volunteer activities or instruction.

THE UNDERSIGNED HAS CAREFULLY READ AND VOLUNTARILY SIGN THE RELEASE.

_____ _____

Signature Date

Please return to:
Volunteer Coordinator
Email: csummers@co.logan.oh.us
fax: 937-592-6746

6/13/18